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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.

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DEQ PROPOSES TO APPROVE CLEANUP PLAN ASHLAND RAILROAD YARD ASHLAND, OREGON

COMMENTS DUE: Jan. 31, 2017
PROJECT LOCATION: Ashland Railroad Yard, Ashland
PROPOSAL: DEQ proposes to approve Union Pacific Railroad's plan to begin cleanup of the 20-acre Ashland railroad yard in mid-2017. The plan includes the following key actions:

- Excavate about 17,500 cubic yards of shallow contaminated soils from two contaminated areas.
- Remove and dispose of contaminated soil and debris from two man-made ponds and a former locomotive drip slab.
- Transport contaminated materials to a permitted landfill using railcars.
- Backfill and re-grade excavated areas using clean soil brought into the railroad yard from offsite using trucks.
- Stockpile clean soil and contaminated soil temporarily onsite in order to coordinate with excavation activities and the delivery of railcars.

BACKGROUND: The Ashland railroad yard is a vacant 20-acre parcel that was used between 1887 and 1986 as a locomotive fueling, maintenance, and railcar repair facility near downtown Ashland. Shallow soil and groundwater in portions of the vacant railroad yard are contaminated with petroleum hydrocarbons, polynuclear aromatic hydrocarbons, lead and arsenic at levels that are higher than DEQ's cleanup standards for human health if the property were to be developed for residential or commercial uses. The railroad yard cleanup will remove most of the contamination from the site and enable Union Pacific to potentially sell all, or a portion, of the property at some point in the future.

Key project documents can be downloaded by entering site ID #1146 into DEQ's online database at: http://www.deq.state.or.us/lq/ECSI/ecsi.htm.

HOW TO COMMENT: Written comments must be received by Jan. 31, 2017. Comments should be submitted to DEQ's Eugene office, 165 East 7th Street, Eugene, Oregon 97401 or by e-mail at aitken.greg@deq.state.or.us. Questions may also be directed to Greg Aitken by phone at (541) 687-7361.

PUBLIC MEETING: DEQ will host a public meeting to discuss the cleanup plan at 7:30 p.m. Thursday, Jan. 19, 2017 at the Ashland Community Center, at 59 Winburn Way.

THE NEXT STEP: DEQ will consider all public comments before taking final action.

DEQ INVITES COMMENT ON PROPOSED CLEANUP AT WHITE HAWK PROPERTY DEVELOPMENT

COMMENTS DUE: 5 p.m., Jan. 31, 2017
PROJECT LOCATION: 718 Beebe Road, Central Point, Oregon
PROPOSAL: Approval of remedy for the White Hawk Property Development

HIGHLIGHTS: The Oregon Department of Environmental Quality invites public comment on a proposed cleanup of soil contamination at the property. From at least 1939 to approximately 1970, a four-acre portion of the property was used as a fruit orchard. It has also been used for pasture land, grain farming and as a vineyard. Currently, the site is vacant.

The proposed development includes high- and low-density housing and a park is planned to be completed in three phases. DEQ has approved a soil management plan that requires:

- Capping of the park with two feet of imported clean fill soil in landscaped areas, or by asphalt or concrete pavement in hardscape areas and development of a long-term cap maintenance and soil management plan for the park. Some areas must be excavated down two feet. The excavated soil can then be placed in the soil management area (i.e., the proposed paved park area) below the cap or disposed of off-site at an appropriate, lined landfill.
- The northern boundary of the site adjacent to the paved playground area must have a fence with a height of at least six feet. The unpaved road currently on or near the northern property boundary must be either capped with at least six inches of gravel or paved.

HOW TO COMMENT: Send comments to DEQ Project Manager Norman Read at DEQ's Eugene office, 165 E. 7th Avenue, Suite 100, Eugene 97401 or read.norm@deq.state.or.us. For more information contact the project manager at 541-687-7348.

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 ECSI No. 4529 in the Site ID box and click "Submit" at the bottom of the page. Next, click the link labeled ECSI No. 4529 in the Site ID/Info column. If you do not have web access and want to review the project file contact the DEQ project manager.

THE NEXT STEP: After the comment period has closed and DEQ has addressed any comments received, DEQ will allow the White Hawk property development to proceed as long as local, regional, and requirements are met.

ACCESSIBILITY INFORMATION: Documents can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request a document in another format or language, call DEQ in Portland at 503-229-5696, or toll-free in Oregon at 1-800-452-4011, ext. 5696; or email deqinfo@deq.state.or.us.

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 Medical Imaging
Chapter 337

Rule Caption: Supervision specifications for limited x-ray permit candidates while completing practical experience requirements

Date:	Time:	Location:
1-20-17	1 p.m.	Rm. 1-D 800 NE Oregon St. Portland OR

Hearing Officer: Kelly Karraker
Stat. Auth.: ORS 688.555
Stats. Implemented: ORS 688.515
Proposed Amendments: 337-010-0030, 337-010-0031
Last Date for Comment: 1-13-17, 4:30 p.m.
Summary: PUBLIC HEARING ON JAN. 20, 2017: A public hearing on this rulemaking will commence at 1:00 p.m., Friday, Jan. 20, 2017 in Room I-D, 800 NE Oregon Street, Portland, Oregon. Oral public comment will be accepted from 1:00 p.m. until no later than 2:30 p.m.

This rulemaking does two things:

1. Revises who can supervise a temporary limited permit holder who is completing clinical experience requirements. This new rule would delete physician, nurse practitioner or physician assistant as persons who could supervise a temporary limited x-ray permit holder (a trainee), while adding that a permanent limited permit holder may serve as a supervisor in certain situations.

2. Amends the Board's requirements for the way that limited x-ray schools supervise students who have completed didactic training and who are completing clinical requirements. The rule will require each school to designate a clinical coordinator, with specific requirements to oversee temporary permit holders (trainees) who are completing clinical requirements. The rule will require each of the five limited permit schools to provide oversight of the clinical component (which follows the didactic component) for a minimum of 180 hours. Also, regarding a temporary permit holder's clinical requirements, this rule specifies that no more than 35 percent of required x-ray images can be completed through simulation, and that none of the basic required images can be completed through simulation.

Rules Coordinator: Ed Conlow
Address: Board of Medical Imaging, 800 NE Oregon St., Suite 1160A, Portland, OR 97232
Telephone: (971) 673-0216

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Board of Psychologist Examiners
Chapter 858

Rule Caption: Removes "Thirty-Day Letter" requirement from investigation process.

Date:	Time:	Location:
2-22-17	10 a.m.	3218 Pringle Road SE Salem, OR 97302

Hearing Officer: LaReé Felton
Stat. Auth.: ORS 675.110; 676.160-.180
Stats. Implemented: ORS 675.110; 676.160-.180
Proposed Amendments: 858-020-0055
Last Date for Comment: 2-22-17, 5 p.m.
Summary: The proposed amendment modifies the Board's investigation process by eliminating the "Thirty-Day Letter" step required prior to commencing procedures for imposing sanctions. Currently, subsequent to the completion of an investigation and prior to issuing a notice of proposed action, the Board must first issue a letter specifying allegations and requiring a response from the respondent within 30 days. This rule amendment would remove that requirement.
Rules Coordinator: LaReé Felton
Address: Board of Psychologist Examiners, 3218 Pringle Rd. SE, Suite 130, Salem, OR 97302
Telephone: (503) 373-1196

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Columbia River Gorge Commission
Chapter 350

Rule Caption: Adoption of Legal Descriptions for Urban Areas Designated in CRGNSA Act, 16 U.S.C. § 544b(e)

Date:	Time:	Location:
2-14-17	10 a.m.	Fisher's Landing Transit Center Rose Besserman Community Rm. 3510 SE 164th Ave. Vancouver, WA 98683

Hearing Officer: Columbia River Gorge Commission
Stat. Auth.: ORS 196.150; RCW 34.97.015; 16 U.S.C. 544b(e)
Stats. Implemented: ORS 196.150; RCW 34.97.015; 16 U.S.C. 544b(e)
Proposed Adoptions: 350-010-0000, 350-010-0010, 350-010-0020, 350-010-0030, 350-010-0040, 350-010-0050
Proposed Repeals: 350-81-0017
Last Date for Comment: 2-2-17, Close of Business
Summary: This rule adopts legal descriptions for the urban areas designated in the Columbia River Gorge National Scenic Area, 16 U.S.C. § 544b(e). The rule does not change any existing Commission rule or the National Scenic Area Act-it is, in effect, an interpretation of the National Scenic Area Act. The rule will provide greater certainty for landowners and land managers about the precise location of the urban areas. Where the legal descriptions differ from a prior interpretation of an urban area boundary, the legal description will supersede the prior interpretation. Existing uses based on a prior interpretation will be managed in accordance with the existing uses provisions of the Commission's management plan and county land use ordinances administering the plan. The rule does not change any urban area boundary; changes to urban area boundaries may only occur in accordance with 16 U.S.C. § 544b(f) (commonly referred to as "4(f)").

The Commission and Forest Service prepared the legal descriptions of the urban areas with the assistance of land surveyors licensed in Oregon and Washington, and with the assistance of two advisory committees. Prior to filing this rulemaking notice, the Commission

held three public workshops to explain the purpose of the legal descriptions and show areas where the Commission had to use discretion because the maps were unclear. The Commission staff will hold an additional public workshop on January 26, 2017 at 2:00 pm at the Gorge Commission office, 57 NE Wauna Ave., White Salmon, Washington 98672. Persons interested in attending must RSVP to Jason Hildreth, jason.hildreth@gorgecommission.org. Space is limited to approximately 15 persons. If there is greater interest, the Commission will schedule additional workshops as needed.

The deadline for public comment is the deadline for including the comment into the staff report for the rulemaking hearing. The Commission will accept public comment through the end of the public hearing.

Rules Coordinator: Nancy A. Andring
Address: Columbia River Gorge Commission, P.O. Box 730, White Salmon, WA 98672
Telephone: (509) 493-3323, ext. 221

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Commission for the Blind
Chapter 585

Rule Caption: Financial Support for Funding Business Ventures
Stat. Auth.: ORS 346.150
Other Auth.: 183.341
Stats. Implemented: ORS 346.180
Proposed Amendments: 585-010-0310
Last Date for Comment: 1-23-17, 5 p.m.
Summary: Division 10: Financial Support for Funding Business Ventures: Title change and updates language to reflect current practices other than the Business Enterprise Program
Rules Coordinator: Dacia Johnson
Address: Commission for the Blind, 535 SE 12th Ave., Portland, OR 97214
Telephone: (971) 673-1588

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

Rule Caption: Implementation of a New Manufactured Home Ownership Document System

Date:	Time:	Location:
1-17-17	9:30 a.m.	1535 Edgewater St. NW Salem, OR 97304

Hearing Officer: staff
Stat. Auth.: ORS 446.571, 446.581, 446.616, 446.621, 446.631, 446.641, 446.646
Stats. Implemented: ORS 446.566, 446.571, 446.576, 446.581, 446.616, 446.621, 446.631, 446.636, 446.641, 446.646
Proposed Adoptions: Rules in 918-550
Proposed Amendments: Rules in 918-550
Proposed Repeals: Rules in 918-550
Proposed Renumberings: Rules in 918-550
Proposed Ren. & Amends: Rules in 918-550
Last Date for Comment: 1-20-17, 5 p.m.
Summary: These proposed rules align the division's manufactured structure ownership document rules with the division's new electronic manufactured structure ownership document system.
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: Revises the fee schedule for assessments financial institutions pay to the Director.

Date:	Time:	Location:
1-19-17	1:30 p.m.	Conference Rm. F 350 Winter St. NE Salem, OR 97301

Hearing Officer: Alex Cheng
Stat. Auth.: ORS 706.530
Stats. Implemented: ORS 706.530
Proposed Amendments: 441-500-0020
Last Date for Comment: 1-25-17, 5 p.m.
Summary: Under the Oregon Bank Act, the Director of the Department of Consumer and Business Services (DCBS or department) may assess financial institutions a fee under a schedule adopted by rule. In adopting the schedule, the Director takes into consideration three factors: the amount of other moneys available for the director to use in performing the director's duties, the costs the director will incur in performing the director's duties in the year in which the director will collect the fee, and the amount the director needs to establish and maintain a reasonable emergency fund. ORS 706.530. Under long-standing administrative policy, the department interprets the meaning of the term "reasonable emergency fund" as requiring the set-aside of two to four quarters of operating costs.

The department's fee schedule developed under the terms of the statute assesses financial institutions a base fee, and then a variable fee determined by multiplying all assets by a fractional number. The department divides the schedule into tiers in order to equitably assess financial institutions fees based on the institution's size. In 2016, the department adopted a temporary rule that increased assessment rates by five percent and also extended the due date for the fees by 15 days to provide banks and trust companies additional time to pay the revised assessment. The department revised its regulations to make fees more equitable and to ensure that Oregon chartered banks and trust companies pay fees that reasonably reflect the costs of supervision. The changes to fee assessments under the proposed rule incorporate the five percent increase under the temporary rule and raises the assessment by 2.5 percent for a total increase of approximately 7.5 percent.

Operating revenue for the banking program is calculated on the average assets of Oregon based institutions, based on quarterly Call Reports of Condition and Income filed with the applicable federal supervisory agency for the calendar year immediately preceding the due date of the fee assessment. Since 2010, the revenue for the banking program has dropped significantly due to the declining number of Oregon state-chartered banks. As a consequence, and despite best efforts to control expenses, between FY 2009 and FY 2014, expenses have exceeded revenues every year except in FY 2012 when the banking program intentionally left examiner positions vacant and received higher than normal amounts of risk-based assessment premiums due to the large number of banks that required more supervision based on their less-than-satisfactory ratings. The revised fees are not being used to pay for an expansion of the banking program or to cover the cost of any special pay increases to banking program employees; rather, the increase in fees will help to cover the ongoing expenses of the banking program.
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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Rule Caption: Revises authority to engage in interest rate swap transactions and use of evaluations for OREO

Date:	Time:	Location:
1-19-17	9:30 a.m.	Conference Rm. E 350 Winter St. NE Salem, OR 97301

Hearing Officer: Alex Cheng
Stat. Auth.: ORS 706.790; 706.795
Stats. Implemented: ORS 708A.010; 708A.175
Proposed Amendments: 441-505-3090, 441-505-3030

Last Date for Comment: 1-25-17, 5 p.m.
Summary: Please note that this rulemaking involves two parts: OAR 441-505-3090 and 441-505-3030. In 2012, the Department of Consumer and Business Services (DCBS or department) adopted OAR 441-505-3090 permitting Oregon chartered banks to act, as an intermediary, in customer-driven interest rate swap transactions and to pledge bank assets as collateral for such transactions. In 2015, the legislature amended ORS 708A.010 to clarify that Oregon banks could engage, as principal or agent, in activities permissible for national banks. The proposed changes to OAR 441-505-3090 simply update the rule to accommodate the legislative changes to ORS 708A.010 and, under the department's wildcard authority contained in ORS 706.795, expressly provide authority for Oregon chartered banks to pledge collateral to counterparties in connection with swap transactions.

This rulemaking further addresses when Oregon commercial banks may use an evaluation rather than an appraisal to establish the market value of other real estate owned. With respect to OAR 441-505-3030, ORS 708A.175 (3) and (4) require Oregon chartered commercial banks to use appraisals that are current at the time the banks acquire real property to satisfy a lien on a real estate loan. Collectively, property acquired under ORS 708A.175(3) and (4) is known as Other Real Estate Owned (OREO). Unlike Oregon commercial banks, national banks may use an evaluation rather than an appraisal to establish the market value of OREO when its value is less than $250,000. 12 C.F.R. § 34.43. The proposed changes to OAR 441-505-3030 will enhance and maintain competition between Oregon chartered commercial banks and national banks by allowing Oregon banks to use evaluations determine the fair market value of OREO under similar circumstances. Where the value of the property is over $250,000, the proposed changes also give banks three months time following the date the property is acquired as OREO to obtain an appraisal.
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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Rule Caption: Implements NMLS registration and renewal processes, removes fee cap for non-profit credit repair entities.

Date:	Time:	Location:
1-23-17	2 p.m.	Conference Rm. 260 350 Winter St. NE Salem, OR 97301

Hearing Officer: Ethan Baldwin
Stat. Auth.: ORS 697.840
Stats. Implemented: ORS 697.632
Proposed Amendments: Rules in 441-910
Last Date for Comment: 1-27-17, 5 p.m.
Summary: These proposed rules establish the process by which registrants and applicants for a debt management service provider submit applications, renewals, and other information through the Nationwide Mortgage Licensing System and Registry (NMLS). Currently, registered debt management service providers and applicants submit registration materials by paper documentation. The department found the current registration system needed for greater efficiency and to facilitate uniformity for multi-state entities. The NMLS creates efficiencies for the industry, consumers, and department as a replacement for the current system. These proposed rules modify and clarify the registration and application procedures to make the use of the NMLS mandatory. This includes all registration and renewal activity, including surety bonds, for debt management service providers to the NMLS. These proposed rules are necessary to enact a uniform application process resulting in greater efficiencies to the state and industry.

ORS 697.612 exempts non-profit entities that provide advice, assistance, instructional materials in return for a fee reasonably calculated to pay the cost of making the advice, assistance, or material available. Currently the rules cap reasonably fees at $25. The department has learned that the current $25 cap is too low to reasonably cover the cost of those services and it is impacting the availability of credit repair services in Oregon. These proposed rules would add a requirement that credit repair organizations comply with the federal Credit Repair Organizations Act, and provide that $25 an hour with a monthly cap of $150 with an overall cap of $300 per consumer is a reasonably calculated fee.
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 Corrections
Chapter 291

Rule Caption: Specify the duties of parole and probation officers of the Department of Corrections.
Stat. Auth.: 137.610, 137.630, 179.040, 423.020, 423.030 and 423.075
Stats. Implemented: 137.610, 137.630, 179.040, 423.020, 423.030 and 423.075
Proposed Amendments: 291-065-0006, 291-065-0007
Last Date for Comment: 2-14-17, 4:30 p.m.
Summary: These amendments are necessary to update the definitions with current terminology.
Rules Coordinator: Janet R. Worley
Address: Department of Corrections, 2575 Center St. NE, Salem, OR 97301-4667
Telephone: (503) 945-0933

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Rule Caption: Use of Force for Parole and Probation Officers
Stat. Auth.: 179.040, 423.020, 423.030, 423.075
Stats. Implemented: 179.040, 423.020, 423.030, 423.075
Proposed Amendments: 291-022-0115, 291-022-0130, 291-022-0170
Last Date for Comment: 2-14-17, 4:30 p.m.
Summary: These amendments are necessary to establish in rule that parole officers are required to wear protective body armor whenever an officer leaves an assigned work location to perform field related duties, and clarify parole officers may carry a department-issued firearm while off duty if authorized by the Assistant Director of Community Corrections.
Rules Coordinator: Janet R. Worley
Address: Department of Corrections, 2575 Center St. NE, Salem, OR 97301-4667
Telephone: (503) 945-0933

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Department of Fish and Wildlife
Chapter 635

Rule Caption: Treaty Indian Fisheries In the Columbia River.

Date:	Time:	Location:
2-10-17	8 a.m.	9000 SW Washington Square Rd. Tigard, OR 97233

Hearing Officer: Oregon Fish and Wildlife Commission
Stat. Auth.: ORS 183.325, 506.119
Stats. Implemented: ORS 506.129, 507.030
Proposed Adoptions: Rules in 635-041
Proposed Amendments: Rules in 635-041
Proposed Repeals: Rules in 635-041
Last Date for Comment: 2-10-17, Close of Hearing
Summary: These amended or adopted rules, as determined justified, will ensure consistent regulatory language and enforcement of Treaty Indian fisheries on the Columbia River by State and Tribal authorities. 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 Forestry
Chapter 629

Rule Caption: Expanding water protection rules to include small and medium salmon, steelhead and bull trout streams.

Date:	Time:	Location:
1-30-17	4 p.m.	EcoTrust 721 NW 9th Ave, Suite 200 Portland, OR 97209

Hearing Officer: Greg Wagenblast
Stat. Auth.: ORS 527.710, 527.630(3), 527.714, 526.016(4)
Stats. Implemented: ORS 527.630(5), 527.674, 527.714, 527.715, 527.765, 527.710, 527. 919(9)
Proposed Adoptions: 629-642-0105, 629-642-0110
Proposed Amendments: 629-600-0100, 629-605-0170, 629-605-0173, 629-605-0500, 629-611-0000, 629-615-0300, 629-620-0300, 629-620-0400, 629-620-0800, 629-623-0300, 629-625-0100, 629-625-0430, 629-625-0700, 629-630-0600, 629-630-0700, 629-630-0800, 629-635-0100, 629-635-0110, 629-635-0200, 629-635-0210, 629-635-0310, 629-680-0020
Proposed Ren. & Amends: 629-640-0000 to 629-642-0000; 629-640-0100 to 629-642-0100; 629-640-0105 to 629-642-0200; 629-640-0110 to 629-642-0300; 629-640-0200 to 629-642-0400; 629-640-0210 to 629-642-0500; 629-640-0300 to 629-642-0600; 629-640-0400 to 629-642-0700; 629-640-0500 to 629-642-0800
Last Date for Comment: 3-1-17, 5 p.m.
Summary: Due to inclement weather, the rulemaking hearings previously scheduled for December 8th in Dallas and Salem, and December 15th in Portland, were cancelled. We have added a new hearing date of January 30th from 4:00 p.m.–7:00 p.m. in Portland, OR at EcoTrust, 721 NW 9th Ave (Suite 200), Portland OR 97209. This new hearing date will conclude the public hearing process.

The following rule summary and Statement of Need and Fiscal Impact is a replicate of the materials filed one month ago.

The Oregon Department of Forestry (ODF) has revised and added proposed rule language for additional resource protection requirements on small and medium sized Salmon, Steelhead, and/or Bull Trout (SSBT) streams located in western Oregon. The new requirements also extend up within the immediate harvest unit above the end of mapped SSBT streams, along the main stem of fish-bearing streams.

The amendment of OAR 629-600-0100 includes definitions for Salmon, Steelhead, and Bull Trout and definitions to classify Type SSBT streams.

The amendment of OAR 629-635-0200 describes how to designate Type SSBT streams and SSBT use. The proposed rules also provide information on when the rules become effective and updates to beneficial use designations.

OAR 629-640 has been removed and renumbered to 629-642 with the inclusion of additional SSBT stream rules.

The adoption of OAR 629-642-0105 requires additional riparian overstory protection on SSBT streams. The proposed rule requires remaining trees in the riparian management area be well distributed and describes alternative prescriptions.

The adoption OAR 629-642-0110 allows relief to be provided to landowners who meet applicable criteria.

Review of this proposed rulemaking package may be accessed on the Department's web page at http://www.oregon.gov/ODF/AboutODF/Pages/ProposedLawsRules.aspx or at the office of the State Forester and are available upon request. Associated supporting materials presented at the September 2016 Board of Forestry meeting are available online. They may be accessed through the Board of Forestry website: www.oregonforestry.gov.

Eight joint open houses and public hearings regarding this rulemaking process were held in Silverton, Keizer, Roseburg, Coos Bay, Florence, Astoria, Springfield, and Forest Grove throughout the month of November and early December. The ninth hearing date in Portland will conclude the public hearing process. Notice of the meetings and hearings will be promoted via flyers, email, media releases and our website prior to the meeting dates.

Written comments must be received by 5:00 p.m. on March 1st, 2017. Submissions should be addressed to: Private Forest SSBT Rulemaking, Oregon Department of Forestry, 2600 State Street, Oregon 97310; or send to RiparianRule@oregon.gov or via fax (503) 945-7490.

Comments received by 5:00 p.m. on March 1st, 2017 will be compiled and incorporated into information presented to the Board of Forestry for their review. From this information and the prior work with this rulemaking process, the Board of Forestry will decide whether to approve this proposed rulemaking package. The Department is planning to present this information at the April Board of Forestry meeting. The Department will propose an effective date of July 1, 2017.
Rules Coordinator: Sabrina Perez
Address: Department of Forestry, 2600 State St., Salem, OR 97310
Telephone: (503) 945-7210

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

Rule Caption: Oregon Deaf and Hard of Hearing Services Advisory Committee

Date:	Time:	Location:
1-26-17	2 p.m.	Human Services Bldg. 500 Summer St NE, Rm. 160 Salem, OR 97301

Hearing Officer: Staff
Stat. Auth.: ORS 410.070, 410.740
Stats. Implemented: ORS 410.740
Proposed Adoptions: 411-019-0000, 411-019-0010, 411-019-0020, 411-019-0030
Last Date for Comment: 1-27-17, 5 p.m.
Summary: The Department of Human Services (Department) is proposing to adopt rules for the Oregon Deaf and Hard of Hearing Services Advisory Committee in OAR chapter 411, division 019 to establish in rule, the structure of the Oregon Deaf and Hard of Hearing Services, (ODHHS) advisory committee. The new rules include a new membership configuration that will embody all affiliations within the Deaf and Hard of Hearing population and the purpose and responsibilities of the advisory committee. This change will empower, improve, and strengthen the voices of Deaf and Hard of Hearing people within the State of Oregon.

The Department is re-filing this notice and re-scheduling the hearing due to hazardous weather conditions on the day the original hearing was scheduled

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

Department of State Police
Chapter 257

Rule Caption: Amend rules to clarify when a tow business or employee can be denied from participation

Date:	Time:	Location:
1-19-17	10 a.m.	DPSST 4190 Aumsville Hwy Salem, Oregon 97317

Hearing Officer: Lt. Jeff Lewis
Stat. Auth.: ORS 181A.350 (former ORS 181.440)
Stats. Implemented: ORS 181A.350 (former ORS 181.440)
Proposed Amendments: 257-050-0050, 257-050-0145
Last Date for Comment: 1-19-17, 10 a.m.
Summary: A Temporary rule change was made on November 18, 2016. This action seeks to make permanent those changes.

OAR 257-050-0145 dictates the conditions under which a tow business owner or employee is disqualified from participation in the OSP non-preference tow program based on felony convictions. Prior to the temporary rule change, the rules stated that if a tow business, a qualified tow business or an owner or employee is convicted of certain felony offenses, the Department "shall deny, suspend, or revoke a tow business' application or a qualified tow business' letter of appointment..." Under those rules, if any employee is ineligible based on any described felony convictions, the entire tow business or qualified tow business becomes ineligible to participate in the non-preference tow program. The temporary rule and these proposed permanent rule amendments narrow "employee" to "driver," clarify to whom and to what entities the felony conviction prohibitions apply, and will allow a tow business or qualified tow business to remain eligible to participate in the program if it prevents a disqualified driver from engaging in any work that is referred to the business by the Department. The proposed amendments are intended to provide flexibility to allow otherwise-eligible tow businesses and qualified tow businesses to continue participating in the non-preference tow program by segregating ineligible drivers and preventing them from participation in the Department's non-preference tow program. However, with the additional clarifications, the proposed rule amendments maintain the current requirement that a tow business will be ineligible to receive a letter of appointment for participation in the Department's non-preference tow program, or a qualified tow business' existing letter of appointment will be revoked, if the tow business, qualified tow business, a manager of daily operations or a principal of the business is disqualified based on any of the felony convictions specified in OAR 257-050-0145.

The proposed rule amendments will also require that OSP be notified if a qualified tow business, tow business, manager of daily operations, or principal becomes aware that a driver is ineligible because of any disqualifying felony conviction and will clarify that OSP may conduct LEDS checks or check court records to determine the existence of felony convictions.

OAR 257-050-0050 has also been amended to add definitions for new terms that are used in the amendments to OAR 257-050-0145 and for terms that previously were not defined.

Rules Coordinator: Shannon Peterson
Address: Department of State Police, 255 Capitol St. NE, 4th Floor, Salem, OR 97310
Telephone: (503) 934-0183

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Department of State Police,
Office of State Fire Marshal
Chapter 837

Rule Caption: Implement HB 3225 coordinated response to oil, hazardous material spills, or releases during rail transport

Date:	Time:	Location:
1-17-17	1 p.m.	3565 Trelstad Ave SE Salem, OR 97317 Timothy McLain Conference Rm.

Hearing Officer: Kristin Schafer
Stat. Auth.: ORS 453.392
Other Auth.: HB 3225 (chapter 739, 2015 laws)
Stats. Implemented: ORS 453.392–453.394
Proposed Adoptions: 837-120-0501, 837-120-0510, 837-120-0520, 837-120-0530, 837-120-0540
Last Date for Comment: 1-17-17, 5 p.m.
Summary: HB 3225 relates to safe rail transport of hazardous materials.

Requires a plan for coordinated response to oil or hazardous material spills or releases that occur during rail transport.

Requires annual report to be submitted to Legislative Assembly.

Identify a repository to inventory hazardous materials response resources.

Rules Coordinator: Valerie Abrahamson
Address: Department of State Police, Office of State Fire Marshal, 4760 Portland Rd. NE, Salem, OR 97305-1760
Telephone: (503) 934-8211

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Department of State Police,
Oregon State Athletic Commission
Chapter 230

Rule Caption: This rule amendment allows weigh-ins to be conducted beyond 24 hours prior to the event.

Date:	Time:	Location:
2-7-17	10 a.m.	DPSST 4190 Aumsville Hwy SE Salem, OR 97317

Hearing Officer: Trista Robischon
Stat. Auth.: ORS 463.113
Stats. Implemented: ORS 463.025 & ORS 463.113
Proposed Amendments: 230-030-0150
Last Date for Comment: 2-7-17, Close of Business
Summary: OAR 230-030-0150 Dictates the procedure for which competitors are weighted in at an Oregon State Athletic Commission regulated event. Subsection two states that boxing and mixed martial arts competitors shall be officially weighted within twenty-four hours prior to the commencement of the event.

Current research shows that allowing weigh -in more than twenty-four hours prior to the event allows competitors more time to re-hydrate. This allows the commission to better protect the health and safety of the competitors.

Rules Coordinator: Trista Robischon
Address: Department of State Police, Oregon State Athletic Commission, 4190 Aumsville Hwy SE, Salem, OR 97317
Telephone: (503) 378-3580

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

Rule Caption: Changes advisory committee member term from a fixed period to variable period
Stat. Auth.: ORS 184.616, 184.619, 802.010 and ORS 802.370
Other Auth.: None
Stats. Implemented: ORS 802.370
Proposed Amendments: 735-150-0005
Last Date for Comment: 1-23-17, 4 p.m.
Summary: OAR 735-150-0005 establishes the Oregon Dealer Advisory Committee (ODAC) as the advisory committee required under ORS 802.370. The rule includes provisions for the designation of members, committee member terms and the appointment and interest of member representation.

Currently, ODAC members serve a fixed three-year term at the pleasure of the DMV Administrator. Over time and due to unforeseen circumstances, multiple committee member terms now expire at the same time. The proposed amendment of OAR 735-150-0005 changes member terms from a fixed three-year term to a variable term of up to three years. The revision provides greater flexibility in making appointments to ensure committee continuity.

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: Annual re-adoption of IRP, HVUT and IFTA regulations
Stat. Auth.: ORS 184.616, 184.619, 823.011, 826.003
Other Auth.: None
Stats. Implemented: ORS 803.370(5), 825.490, 825.494, 825.555, 826.005, 826.007
Proposed Amendments: 740-200-0010, 740-200-0020, 740-200-0040
Last Date for Comment: 1-23-17, 4 p.m.
Summary: The proposed amendment constitutes an adoption of the rules of the International Registration Plan (IRP) to the date of January 1, 2017. Interest is not charged in an audit assessment. The proposed rulemaking removes this requirement and aligns the Department with IRP requirements. Title 26 Code of Federal Regulations Part 41 (HVUT) requires the State to confirm proof of payment of the tax, and require proof of payment by the State as a condition of issuing a registration for a highway motor vehicle. The amendment of OAR 740-200-0020 adopts HVUT and amendments with the effective date of January 1, 2017, and ensures Oregon remains current with national commercial motor vehicle registration standards. International Fuel Tax Agreement (IFTA) and associated material are applicable to Oregon-based motor carriers who participate in IFTA as a way to report and pay fuel tax to other jurisdictions. The revision to OAR 740-200-0040 adopts the most recent version of IFTA and associated material as the procedures and guidelines for Oregon-based IFTA participants with the effective date of January 1, 2017 to ensure Oregon remains current with the international IFTA standards.
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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Employment Department
Chapter 471

Rule Caption: Update Rule to Incorporate 2013 Statutory Change and Clarify Unemployment Coverage for Certain Corporate Officers

Date:	Time:	Location:
1-27-17	2 p.m.	Employment Dept. Auditorium 875 Union St NE, Salem, OR 97311

Hearing Officer: Staff
Stat. Auth.: ORS 657.610
Stats. Implemented: ORS 657.044
Proposed Amendments: 471-031-0017
Last Date for Comment: 1-27-17, 5 p.m.
Summary: The Department is proposing to amend this rule due to the passage of Senate Bill (SB) 849 in the 2013 Legislative Session. SB 849 amended Oregon Revised Statute (ORS) 657.044 to enable corporations with sole corporate officers to elect not to provide unemployment insurance coverage for the officers. The bill specified that the exclusion applied when Oregon achieved Unemployment Insurance Tax Schedule IV or lower which occurred in 2016.

The proposed amendment also includes the following changes, not resulting from the passage of SB 849, to simplify the rule:

(1) Clarifies how the Department will review the written election;

(2) Simplifies how a corporation may cancel said election;

(3) Specifies when the election is considered revoked due to a corporation no longer meeting the requirements of ORS 657.044; and

(4) Removes redundant or otherwise unnecessary references to authority and rights established under existing Oregon law.

Lastly, also not resulting from the passage of SB 849, the proposed amendment to the rule defines the term "substantial ownership" to mean that each corporate officer must own at least ten (10%) percent of the total corporation.

The change in rule will not affect employers who currently already qualify for the exclusion. Only corporations with officers electing the exclusion after February 1, 2017 will be affected.

Written comments may be submitted via e-mail to OED_Rules@oregon.gov by January 27, 2017 at 5:00 p.m. All comments received will be given equal consideration before the Department proceeds with the permanent rulemaking.
Rules Coordinator: Cristina Koreski
Address: Employment Department, 875 Union St. NE, Salem, OR 97311
Telephone: (503) 947-1471

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Land Conservation and Development Department
Chapter 660

Rule Caption: Rulemaking regarding protection of historic resource sites under Statewide Planning Goal 5

Date:	Time:	Location:
1-26-17	8 a.m.	Meriwether Place 1070 Columbia Blvd St. Helens, OR 97051

Hearing Officer: LCDC
Stat. Auth.: ORS 197.040
Other Auth.: Statewide Planning Goal 5 (OAR 660-015-0000(5))
Stats. Implemented: ORS 197.772
Proposed Amendments: 660-023-0200
Last Date for Comment: 1-26-17, Close of Hearing
Summary: The purpose of the proposed amendments are to achieve a well-articulated base level of protection for historic resources listed in the National Register of Historic Places that can be applied directly without the need to amend local codes; clarify the circumstances under which the owner consent provisions in ORS 197.772(1) apply to resources listed in the National Register; better explain how the standard Goal 5 process described is augmented by the Secretary of the Interior's Standards and Guidelines for Archeology and Historic Preservation, published by the National Park Service (NPS); and clarify who has standing under the owner consent provisions of ORS 197.772(2) and highlight an alternate path for removing a local historic designation.
Rules Coordinator: Casaria Taylor
Address: Land Conservation and Development Department, 635 Capitol St. NE, Suite 150, Salem, OR 97301
Telephone: (503) 373-0050, ext. 322

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Rule Caption: Adoption of new rules governing selection of pilot projects that amend UGB for affordable housing

Date:	Time:	Location:
1-26-17	8:30 a.m.	1070 Columbia Blvd, Ste. 10 St. Helens, OR 97051

Hearing Officer: LCDC
Stat. Auth.: ORS197.040; Oregon Laws 2016, Chapter 52
Stats. Implemented: Oregon Laws 2016, Chapter 52
Proposed Adoptions: Rules in 660-039
Last Date for Comment: 1-26-17, Close of Hearing
Summary: In 2016, the Oregon Legislature passed House Bill 4079 (Oregon Laws 2016, Chapter 52, Section 3), which Governor Brown signed it into law. The bill aims to boost affordable housing by allowing two cities to develop affordable and market rate housing on lands currently outside urban growth boundaries (UGBs) without going through the normal UGB expansion process.

The draft rules authorize the Land Conservation and Development Commission (LCDC) to set up a process and select two pilot projects, one for a city with a population up to 25,000, and one for a city

with a population greater than 25,000. Cities in certain counties are excluded from the program as directed in House Bill 4079. The pilot project sites may be no greater than 50 acres, may not be located on high-value farmland, and must be located adjacent to an existing UGB.

The draft rules define "affordable housing" developed under the pilot projects as housing units for rent or sale to households earning 80 percent or less of area median income, spending no more than 30 percent of gross income on rent and utilities.

The draft rules require cities submitting pilot project nominations to submit, first, a preliminary application and then a final application, and specify the required content of these submittals.

The draft rules exempt pilot project nominations from demonstrating compliance with ORS 197A.320 and various provisions of statewide planning goals and implementing administrative rules, most notably the land need or boundary location provisions of Goal 14.

The draft rules require pilot projects to demonstrate that public facilities, including public transit, are available or can be made available to serve the nominated site. The draft rules include measures to ensure appropriate buffering from nearby farm and forest uses. The draft rules include a list of measures from which cities must choose a certain number that demonstrate that cities are taking sufficient measures to accommodate and encourage needed and affordable housing within existing urban growth boundaries. The draft rules set standards for the amount and phasing of affordable housing required in a pilot project. The draft rules also set forth additional considerations that the commission may consider when choosing the two pilot projects from among submitted pilot project nominations.

The draft rules set forth the commission's selection process, subsequent requirements of the cities that have had their pilot project nominations selected by the commission, and ongoing reporting requirements for those cities.

The draft rules authorize the director of the Department of Land Conservation and Development to set submittal deadlines for preliminary and final applications, and allows the director to revise those deadlines if needed to accomplish the purpose of the affordable housing pilot project program.

Rules Coordinator: Casaria Taylor
Address: Land Conservation and Development Department, 635 Capitol St. NE, Suite 150, Salem, OR 97301
Telephone: (503) 373-0050, ext. 322

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Rule Caption: Metropolitan Greenhouse Gas Reduction Targets

Date:	**Time:**	**Location:**
1-26-17	8:30 a.m.	1070 Columbia Blvd St. Helens, OR 97051

Hearing Officer: LCDC
Stat. Auth.: ORS 197.040(1)
Stats. Implemented: Chapter 85, Oregon Laws 2010 (Senate Bill 1059)
Proposed Amendments: Rules in 660-044
Proposed Repeals: 660-044-0010
Last Date for Comment: 1-26-17, Close of Hearing
Summary: The Land Conservation and Development Commission adopted OAR chapter 660, division 44 in response to direction provided in House Bill 2001 (2009) and Senate Bill 1059 (2010) requiring rules setting greenhouse gas emission reductions targets for each of the state's metropolitan areas. The targets are based on transportation planning and measure emissions from motor vehicles with a gross vehicle weight rating of 10,000 pounds or less. At its May 2015 meeting, the Land Conservation and Development Commission determined that amendments to the targets in division 44 are warranted for three reasons: 1) Local governments are adopting transportation plans that look further into the future, beyond the 2035 targets; therefore targets are needed for future years through 2050. 2) New information about trends and projections for vehicle technology, fleet and fuels could affect targets. 3) There are two areas (Albany and Grants Pass) that are now designated as metropolitan areas, but are not included in the initial targets because they were not designated as metropolitan areas when the targets were adopted. The amendments to the rules incorporate the new information gathered through the Rulemaking Advisory Committee process.
Rules Coordinator: Casaria Taylor
Address: Land Conservation and Development Department, 635 Capitol St. NE, Suite 150, Salem, OR 97301
Telephone: (503) 373-0050, ext. 322

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Occupational Therapy Licensing Board
Chapter 339

Rule Caption: Amend 339-010-0020 Unprofessional Conduct to include failure to follow principles in AOTA Code of Ethics.
Stat. Auth.: ORS 675.230, 675.240, 675.250, 675.300 & 675.310
Other Auth.: Board Meeting held on November 7, 2016. December 2016 Newsletter. Board Website.
Stats. Implemented: ORS 675.230, 675.240, 675.250, 675.300 & 675.310.
Proposed Amendments: 339-010-0020
Last Date for Comment: 1-23-17, 12 p.m.
Summary: 339-010-0020 Unprofessional Conduct

(1) Unprofessional conduct relating to patient/client safety, integrity and welfare includes:

(a) Intentionally harassing, abusing, or intimidating a patient/client, either physically or verbally;

(b) Intentionally divulging, without patient/client consent, any information gained in the patient relationship other than what is required by staff or team for treatment;

(c) Engaging in assault and/or battery of patient/client;

(d) Failing to respect the dignity and rights of patient/client, regardless of social or economic status, personal attributes or nature of health problems;

(e) Engaging in sexual improprieties or sexual contact with patient/client;

(f) Offering to refer or referring a patient/client to a third person for the purpose of receiving a fee or other consideration from the third person or receiving a fee from a third person for offering to refer or referring a patient/client to a third person;

(g) Taking property of patient/client without consent.

(h) Failing to follow principles and related standards of conduct as defined in the Occupational Therapy Code of Ethics (2015), by the American Occupational Therapy Association, to the extent they do not conflict with ORS 675.210 through 675.340.

Rules Coordinator: Nancy Schuberg
Address: Occupational Therapy Licensing Board, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0198

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Oregon Board of Naturopathic Medicine
Chapter 850

Rule Caption: Adopts guidelines on ethics into rule
Stat. Auth.: 685.125
Stats. Implemented: 685.110
Proposed Amendments: 850-050-0010, 850-050-0190
Last Date for Comment: 2-12-17, 4 p.m.
Summary: Add as a violation "Failure to act in accordance with the American Association of Naturopathic Physicians (2015) Code of Ethics as adopted by the Board"
Rules Coordinator: Anne Walsh
Address: Oregon Board of Naturopathic Medicine, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0193

Oregon Department of Education
Chapter 581

Rule Caption: Implements Ballot Measure 98: the High School Graduation and College and Career Readiness Act

Date:	Time:	Location:
1-30-17	9:30 a.m.	Rm. 400A, Public Service Bldg. 255 Capitol St. NE Salem, OR

Hearing Officer: Emily Nazarov
Stat. Auth.: Ballot Measure 98 (2016)
Stats. Implemented: Ballot Measure 98 (2016)
Proposed Adoptions: 581-013-0005, 581-013-0010, 581-013-0015, 581-013-0020, 581-013-0025, 581-013-0030, 581-013-0035
Last Date for Comment: 2-23-17, 9 a.m.
Summary: The rules implement Ballot Measure 98 (2016) which established the the High School Graduation and College and Career Readiness Act. The rules establish guidelines for how the Department of Educationwill administer the High School Graduation and College and Career Readiness Fund. The rules establish eligibility requirements for school districts and public charter schools to receive money from the High School Graduation and College and Career Readiness Fund. The rules also establish the reporting, monitoring, and technical assistance process.
Rules Coordinator: Cindy Hunt
Address: Oregon Department of Education, 255 Capitol St. NE, Salem, OR 97310
Telephone: (503) 947-5651

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Rule Caption: Dyslexia Related Teacher Training

Date:	Time:	Location:
1-23-17	1:30 p.m.	400 A, 255 Capitol St. NE Salem Oregon

Hearing Officer: Emily Nazarov
Stat. Auth.: ORS 326.726
Stats. Implemented: ORS 326.726
Proposed Adoptions: 581-002-1800, 581-002-1805, 581-002-1810, 581-022-2440
Last Date for Comment: 1-26-17, 9 a.m.
Summary: These rules establish requirements for dyslexia related training for teachers. The rules provide details for the list of approved training opportunities. The rules also provide requirements for school districts regarding teacher training. They also provide for a waiver of the training requirements for districts.
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,
Oregon Educators Benefit Board
Chapter 111

Rule Caption: Amendments to update benefit plan name changes and other housekeeping updates

Date:	Time:	Location:
1-24-17	10 a.m.	OEBB Boardroom 1225 Ferry St. SE Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860 tot 243.886
Stats. Implemented: ORS 243.864(1)(a)
Proposed Amendments: 111-010-0015
Last Date for Comment: 1-31-17, Close of Business
Summary: Amendments to update benefit plan name changes and other housekeeping updates.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 500 Summer Street NE, E-88, Salem, OR 97301
Telephone: (503) 378-6588

Rule Caption: Amendments to update benefit plan name changes, other housekeeping updates and clarifications

Date:	Time:	Location:
1-24-17	10 a.m.	OEBB Board Rm. 1225 Ferry St. SE Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860 to 243.886
Stats. Implemented: ORS 243.864(1)(a)
Proposed Amendments: 111-030-0010, 111-030-0035, 111-030-0040, 111-030-0045, 111-030-0046, 111-030-0047, 111-030-0050
Last Date for Comment: 1-31-17, Close of Business
Summary: Amendments to update benefit plan name changes, other housekeeping updates and clarifications on rate structures for different groups.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 500 Summer Street NE, E-88, Salem, OR 97301
Telephone: (503) 378-6588

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Rule Caption: Amendments to update benefit plan name changes and other housekeeping updates

Date:	Time:	Location:
1-24-17	10 a.m.	OEBB Boardroom 1225 Ferry St. SE Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860 to 243.886
Stats. Implemented: ORS 243.864(1)(a)
Proposed Amendments: 111-070-0001, 111-070-0005, 111-070-0015, 111-070-0020, 111-070-0040, 111-070-0050
Last Date for Comment: 1-31-17, Close of Business
Summary: Amendments to update benefit plan name changes and other housekeeping updates related to premium payments for the HB2557 population.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 500 Summer Street NE, E-88, Salem, OR 97301
Telephone: (503) 378-6588

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Oregon Health Authority,
Public Health Division
Chapter 333

Rule Caption: Requiring thyroid collar for pediatric patients and administrative changes to radioactive licensees

Date:	Time:	Location:
1-17-17	9 a.m.	Portland State Office Bldg. 800 NE Oregon St., Rm. 1D Portland, OR 97232

Hearing Officer: Jana Fussell
Stat. Auth.: ORS 453.605–453.807
Other Auth.: 10 CFR Parts 37 and 40
Stats. Implemented: ORS 453.605–453.807
Proposed Amendments: 333-102-0005, 333-102-0015, 333-102-0101, 333-106-0325, 333-125-0040, 333-125-0120
Last Date for Comment: 1-22-17, 5 p.m.
Summary: The Oregon Health Authority, Public Health Division, Center for Health Protection is proposing to permanently amend Oregon Administrative rules relating to the X-ray and radioactive materials programs within the Radiation Protection Services (RPS) section.

The Radioactive Materials Licensing (RML) program is proposing to amend rules for a mathematical error by amending Gy to microGy within division 102 and make minor corrections within divisions 102 and 125 in order to be compatible with the Nuclear Regulatory Commission's regulations. These amendments will have no impact to Oregon's licensees since federal regulations are currently being enforced by the RML program.

The X-ray program is proposing to amend rules in division 106 to require all pediatric patients to wear a 0.25 mm lead equivalent thyroid collar to protect the thyroid during intraoral X-ray exposures.
Rules Coordinator: Brittany Hall
Address: Oregon Health Authority, Public Health Division, 800 NE Oregon St., Suite 930, Portland, OR 97232
Telephone: (971) 673-1291

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Oregon Liquor Control Commission
Chapter 845

Rule Caption: The new rule enables remotely located distillery licensees limited shipments to local retail sales agents.

Date:	Time:	Location:
1-17-17	10 a.m.	9079 SE McLoughlin Blvd. Portland, OR 97222

Hearing Officer: Bryant Haley
Stat. Auth.: ORS 471.730
Stats. Implemented: ORS 471.740, 471.750 & 471.754
Proposed Adoptions: 845-015-0142
Last Date for Comment: 1-31-17, 5 p.m.
Summary: Distillery licensees are required to send their products to the Milwaukie warehouse for subsequent distribution to Retail Sales Agents. This is a particularly significant burden for remotely located distillery licensees. This new rule contemplates allowing remotely located distillery licensees to ship products to local retail sales agents without first sending those products to the warehouse on a limited basis. This would be restricted to distillery licensees that ship 1 -25 cases to the Commission on a monthly basis.
Rules Coordinator: Bryant Haley
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5136

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Oregon Military Department,
Office of Emergency Management
Chapter 104

Rule Caption: Implementation of Fuel Storage Facility Compatibility Fund Grant

Date:	Time:	Location:
1-19-17	10 a.m.	3225 State St., Rm. 115 Salem, OR 97301

Hearing Officer: Genevieve Ziebell
Stat. Auth.: ORS 85
Other Auth.: SB 1523 (2016)
Stats. Implemented: ORS 85
Proposed Adoptions: 104-055-0000, 104-055-0010, 104-055-0020, 104-055-0030, 104-055-0040, 104-055-0050, 104-055-0060, 104-055-0070, 104-055-0080, 104-055-0090, 104-055-0100
Last Date for Comment: 1-23-17, 5 p.m.
Summary: ORS 85 created the Fuel Storage Facility Compatibility funds and tasked the Oregon Office of Emergency Management with creating a grant program to disperse the funds. The Proposed Rule implements rules for the administration and implementation of the grant.

Please submit written comments or questions to Sidra Metzger-Hines, Grants Coordinator, Oregon Office of Emergency Management, PO Box 14370, Salem OR, 97309-5062 or via email to sidra.metzgerhines@state.or.us.
Rules Coordinator: Genevieve Ziebell
Address: Oregon Military Department, Office of Emergency Management, PO Box 14370, 3225 State St., Rm. 115, Salem, OR 97309-5062
Telephone: (503) 378-2911, ext. 22221

Oregon Racing Commission
Chapter 462

Rule Caption: Rule to govern Pick (n) Position (x) Pool wagers.

Date:	Time:	Location:
1-19-17	11:30 a.m.	PSOB - 800 NE Oregon St. Portland, OR 97232, Rm. 1C

Hearing Officer: Charles Willliamson
Stat. Auth.: ORS 462-270 (3)
Stats. Implemented: ORS 462-270 (3)
Proposed Adoptions: 462-200-0665
Last Date for Comment: 1-19-17, Close of Hearing
Summary: Rule governs Pick (n) Position (x) Pool wager as adopted by the Association of Racing Commissioners International, Inc. Models Rules of Racing.
Rules Coordinator: Karen Parkman
Address: Oregon Racing Commission, 800 NE Oregon St., Suite 310, Portland, OR 97232
Telephone: (971) 673-0208

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Oregon Tourism Commission
Chapter 976

Rule Caption: Amend Wine Country License Plate rule to closely align with Regional Cooperative Tourism Program Regions

Date:	Time:	Location:
2-7-17	9 a.m.	The Allison Inn & Spa 2525 Allison Ln. Newberg, OR

Hearing Officer: Jeff Hampton
Stat. Auth.: ORS 284.111(6) and 805.274(3)
Stats. Implemented: ORS 805.274
Proposed Amendments: 976-002-0040
Last Date for Comment: 2-1-17, Close of Business
Summary: The amended rule would modify the wine producing regions as identified by the Wine Country License plate administrative rules to better align with the state's seven Regional Cooperative Tourism Program regions.
Rules Coordinator: Sarah Watson
Address: Oregon Tourism Commission, 250 Church St. SE, Suite 100, Salem, OR 97301
Telephone: (503) 967-1568

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Oregon Youth Authority
Chapter 416

Rule Caption: Proposed are housekeeping changes to employee titles. OYA no longer has a Treatment Services Director.
Stat. Auth.: ORS 420A.010, 420A.025, 420A.022
Stats. Implemented: ORS 420A.022
Proposed Amendments: 416-070-0010, 416-070-0020, 416-070-0040, 416-070-0050, 416-070-0060
Last Date for Comment: 1-30-17, Close of Business
Summary: OYA no longer has a Treatment Services Director. The proposed rule amendments reflect current employee titles, and add an option for a designee.
Rules Coordinator: Winifred Skinner
Address: Oregon Youth Authority, 530 Center St. NE, Suite 500, Salem, OR 97301
Telephone: (503) 373-7570

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Public Utility Commission
Chapter 860

Rule Caption: In the Matter of Adopting the 2017 Edition of the National Electrical Safety Code.
Stat. Auth.: ORS 183, 756, 757, 759
Stats. Implemented: ORS 757.035
Proposed Amendments: 860-024-0010
Last Date for Comment: 1-23-17, 5 p.m.

Summary: The proposed amendments to OAR 860-024-0010 adopt the latest edition of the National Electrical Safety Code (NESC). Every five years the NESC is revised by a volunteer group of industry experts, with the Institute of Electrical and Electronics Engineers (IEEE) acting as the secretariat, and then is approved by the American National Standards Institute. The 2017 NESC was published in August 2016 and has an effective date of February 1, 2017. The PUC's adoption by rule of the latest NESC edition requires subject operators to stay up to date with current national standards and practices used in the construction, operation, and maintenance of electric supply lines and communication lines.

The PUC encourages participants to file written comments before the last day of the comment period, January 23, 2017, so that other participants have the opportunity to consider and respond to the comments before the close of the comment period. Please reference Docket No. AR 606 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=20419. 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.

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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Veterinary Medical Examining Board
Chapter 875

Rule Caption: Requires Board-approved radiation safety training for unlicensed persons.

Stat. Auth.: 686.210

Stats. Implemented: 686.350–686.370

Proposed Amendments: 875-030-0050

Last Date for Comment: 1-9-17 Close of Business

Summary: Eliminates obsolete reference to Oregon Health Division requirements, establishes Board as approving authority.

Rules Coordinator: Lori V. Makinen

Address: Veterinary Medical Examining Board, 800 NE Oregon St., Suite 407, Portland, OR 97232

Telephone: (971) 673-0224

Board of Licensed Professional Counselors and Therapists
Chapter 833

Rule Caption: Approval of the California Marriage and Family Therapist Written Clinical Examination.
Adm. Order No.: BLPCT 5-2016(Temp)
Filed with Sec. of State: 12-12-2016
Certified to be Effective: 12-12-16 thru 6-9-17
Notice Publication Date:
Rules Amended: 833-040-0041
Subject: This amendment adds the State of California Board of Behavioral Sciences' Marriage and Family Therapist Written Clinical Examination as an approved competency examination for licensure as a Licensed Marriage and Family Therapist (LMFT) in Oregon.
Rules Coordinator: LaReé Felton—(503) 373-1196

833-040-0041
Examination Requirement for Licensure as a Marriage and Family Therapist

(1) All applicants for licensure as a marriage and family therapist must pass a competency examination and an Oregon law and rules examination pursuant to OAR 833-020-0081.

(2) To qualify for licensure as a marriage and family therapist under ORS 675.715(1)(d), an applicant must pass, or have passed within ten years prior to the date the application was received by the Board, an approved competency examination.

(3) The Board prescribes the following as approved competency examinations:

(a) The marital and family therapy examination of the Association of Marital and Family Therapy Regulatory Boards (AMFTRB); and

(b) The State of California Board of Behavioral Sciences' Marriage and Family Therapist Written Clinical Examination.

(4) Applicants applying via the reciprocity method may meet the competency exam requirements specified in 833-020-0081.

(5) To qualify to sit for the competency examination, a LMFT applicant must:

(a) Submit an application; and

(b) Meet the graduate program and coursework requirements prescribed in OAR 833-040-0011.

(6) Candidates will pay exam and exam administration fees to the prescribed examination providers.

(7) Passing scores will be:

(a) Established by the AMFTRB for applicants who plan to take the exam after making application for Oregon licensure; or

(b) Established by the agency verifying passage of its examination for applicants who have completed an approved alternative examination.

(8) The Board will notify examinees in writing of the results of their examination.

(9) Following passage of the approved competency examination, the Board requires passage of an Oregon state law and rules examination, with a passing score as determined by the Board.

Stat. Auth.: ORS 675.785 - 675.835 & 676.160 - 676.180
Stats. Implemented: ORS 675.785 - 675.835
Hist.: BLPCT 1-2010, f. & cert. ef. 1-5-10; BLPCT 3-2010, f. 4-30-10, cert. ef. 5-3-10; BLPCT 1-2013, f. 1-11-13, cert. ef. 2-1-13; BLPCT 4-2016, f. & cert. ef. 10-10-16; BLPCT 5-2016(Temp), f. & cert. ef. 12-12-16 thru 6-9-17

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Board of Nursing
Chapter 851

Rule Caption: Revise rules regarding Board Administration including an increase in Board compensation.
Adm. Order No.: BN 8-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 9-1-2016
Rules Adopted: 851-010-0000
Rules Amended: 851-010-0005, 851-010-0010, 851-010-0015, 851-010-0024, 851-010-0035
Rules Repealed: 851-010-0020
Subject: Amend OAR 851-010 related to Board Administration
Rules Coordinator: Peggy A. Lightfoot—(971) 673-0638

851-010-0000
Definitions

Board: Means the Oregon State Board of Nursing.

Stat. Auth: ORS 678.150 & 292.495
Stats. Implemented: ORS 678.150
Hist.: BN 8-2016, f. 11-28-16, cert. ef. 1-1-17

851-010-0005
Duties

(1) Board Officers:

(a) President:

(A) Preside at all Board meetings.

(B) Confer with the Executive Director of the Board on matters that come up between meeting dates, and matters that need to be placed on the agenda for Board meetings. The ordering or reordering of the agenda is the prerogative of the President.

(C) Executes all Board orders.

(D) Coordinates and conducts the evaluation of the Executive Director.

(b) Secretary: Call the roll for meetings and declare the presence of a quorum. In the absence of the Secretary, the President shall appoint a Secretary Pro Tem. In the absence of the President and President Elect, the Secretary shall perform all duties of the President.

(2) Board Members: In addition to duties required under ORS 678.140 through ORS 678.153 the following describe the duties of all Board members:

(a) Participation in the evaluation of the Executive Director.

(b) Participate on committees as requested by the Board.

(c) Participate in the approval of the Agency Budget.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NER 1, f. 11-12-57; NER 40, f. & ef. 11-25-77; BN 4, f. & cert. ef. 4-24-00; BN 8-2016, f. 11-28-16, cert. ef. 1-1-17

851-010-0010
Election

The officers of the Board shall be elected annually, officers may be elected for consecutive terms. Elections shall be held on the second day of a regularly scheduled Board meeting. Terms of office shall run from January 1st to December 31st.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NER 1, f. 11-12-57; NER 40, f. & ef. 11-25-77; NB 1-1997, f. & cert. ef. 1-2-97; BN 12-2001, f. & cert. ef. 10-16-01; BN 7-2005, f. & cert. ef. 10-13-05; BN 8-2016, f. 11-28-16, cert. ef. 1-1-17

851-010-0015
Vacancies in Office

A Board Officer vacancy shall be filled by election occurring during the next public day of a regularly scheduled board meeting. The elected Board Member shall fulfill the term of the vacancy.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NER 1, f. 11-12-57; NER 40, f. & ef. 11-25-77; BN 4, f. & cert. ef. 4-24-00; BN 8-2016, f. 11-28-16, cert. ef. 1-1-17

851-010-0024
Board Member Compensation

(1) A Board member shall receive up to $150 stipend for each day or portion thereof during which the member is engaged in the performance of official duties.

(2) Performance of official duties is defined as:

(a) Scheduled meetings:

(A) Board meetings, including special Board meetings via conference call,

(B) Board committee meetings.

(b) Appointments with Board staff for Board business;

(c) Legislative testimony; OR

(d) Conferences and activities that the Board has requested that the member attend as its representative.

(3) Each Board member shall receive a two day stipend for each regularly scheduled Board meeting preparation. This compensation is waived if the Board member does not attend the meeting for which they have prepared.

Stat. Auth: ORS 678.150 & 292.495
Stats. Implemented: ORS 678.150
Hist.: BN 1-2010(Temp), f. & cert. ef. 1-21-10 thru 6-18-10; BN 5-2010, f. & cert. ef. 4-21-10; BN 8-2016, f. 11-28-16, cert. ef. 1-1-17

851-010-0035
Meetings

Additional meetings may be held when necessary. Meeting dates are approved by the Board. The agenda for Board members to review shall be sent to them at least twelve days prior to the regular meeting date.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NER 1, f. 11-12-57; NER 40, f. & ef. 11-25-77; NER 5-1983, f. 12-9-83, ef. 1-1-84; BN 4, f. & cert. ef. 4-24-00; BN 8-2016, f. 11-28-16, cert. ef. 1-1-17

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Board of Pharmacy
Chapter 855

Rule Caption: Adopts and amends various rules in Division 019 and 041 and 080
Adm. Order No.: BP 6-2016
Filed with Sec. of State: 12-14-2016
Certified to be Effective: 12-14-16
Notice Publication Date: 11-1-2016
Rules Adopted: 855-019-0450, 855-019-0455, 855-019-0460, 855-041-2340
Rules Amended: 855-019-0120, 855-080-0021
Rules Repealed: 855-019-0450(T), 855-019-0455(T), 855-019-0460(T), 855-041-2340(T)
Subject: The Board permanently adopted the following rules at it's December 7, 2016 Board meeting.

Changes to Division 019 - Reduce the number of days before eligibility to retake the NAPLEX. Limits the number of retakes on the NAPLEX and MPJE exams to no more than three times in one year for a lifetime maximum of five attempts. This change is consistent with the National Association of Boards of Pharmacy (NABP) new policy that changed on 11/1/16.

Changes to Divisions 019 & 041 - Permanently incorporates new statutory language put forth by House Bill 4124 (2016) related to Naloxone. The bill permits pharmacists to prescribe and distribute unit-of-dose packages of naloxone to individuals who conduct or complete OHA approved training. It allows a trainer to possess and distribute naloxone to trainees, and allows trainees to possess and administer naloxone to an individual experiencing an opiate overdose. The rule (1) gives the purpose; (2) specifies the qualifications of participating pharmacists and individuals; and (3) outlines the delivery of care expectations for the pharmacist and pharmacy, including documentation and recordkeeping.

Changes for Division 080 - Permanently add synthetic opioids/fentanyl derivatives (known as U-47700 and W-18) to Oregon Schedule CI drugs. Schedule I also includes any substituted derivatives of fentanyl that are not specifically listed, or are not FDA approved.
Rules Coordinator: Karen MacLean—(971) 673-0001

855-019-0120
Licensure

(1) Before licensure as a pharmacist, an applicant must meet the following requirements:

(a) Provide evidence from a school or college of pharmacy approved by the Board that they have successfully completed all the requirements for graduation and, starting with the graduating class of 2011, including not less than 1440 hours of School-based Rotational Internships as that term is defined in OAR 855-031-0005, and that a degree will be conferred;

(b) Pass the North American Pharmacist Licensure Examination (NAPLEX) exam with a score of not less than 75. This score shall remain valid for only one year unless the Board grants an extension. A candidate who does not attain this score may retake the exam after a minimum of 45 days with a limit of three attempts in a 12 month period, not to exceed a lifetime maximum of 5 times.

(c) Pass the Multistate Pharmacy Jurisprudence Examination (MPJE) exam with a score of not less than 75. The applicant may not take the MPJE until they have graduated from a school or college of pharmacy approved by the Board. A candidate who does not attain this score may retake the exam after a minimum of 30 days with a limit of three attempts in a 12 month period, not to exceed a lifetime maximum of 5 times. The MPJE score shall be valid for 6 months unless extended by the Board;

(d) Complete an application for licensure, provide the Board with a valid e-mail address, and a fingerprint card or other documentation required to conduct a criminal background check.

(2) A license, once obtained, will expire on June 30 in odd numbered years and must be renewed biennially.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.151
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; 1PB 1-1981(Temp), f. & ef. 4-1-81; 1PB 2-1981, f. & ef. 8-20-81; 1PB 3-1985, f. & ef. 12-2-85; PB 3-1991, f. & cert. ef. 9-19-91; 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; BP 1-2002, f. & cert. ef. 1-8-02; Renumbered from 855-019-0005, BP 2-2008, f. & cert. ef. 2-20-08; BP 3-2010, f. 4-29-10, cert. ef. 4-30-10; BP 4-2011, f. 6-24-11, cert. ef. 7-1-11; BP 10-2014, f. 12-30-14, cert. ef. 1-1-15; BP 6-2016, f. & cert. ef. 12-14-16

855-019-0450
Purpose

The purpose of OAR 855-019-0450 through 855-019-0460 is to develop standard procedures for the prescribing and recordkeeping of naloxone by a pharmacist in Oregon.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305, 689.681 & 2016 OL Ch. 100
Hist.: BP 5-2016(Temp), f. & cert. ef. 9-7-16 thru 3-5-17; BP 6-2016, f. & cert. ef. 12-14-16

855-019-0455
Qualifications

A pharmacist educated in opiate overdose and naloxone rescue can prescribe unit-of-use naloxone and the necessary medical supplies to administer the naloxone for an individual who:

(1) Conducts training that meets that criteria established by the Oregon Health Authority (OHA) so that the person may possess and distribute naloxone and the necessary medical supplies to persons who successfully complete the training; or

(2) Has successfully completed training that meets criteria established by the OHA allowing the person to possess and administer naloxone to any individual who appears to be experiencing an opiate overdose.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305, 689.681 & 2016 OL Ch. 100
Hist.: BP 5-2016(Temp), f. & cert. ef. 9-7-16 thru 3-5-17; BP 6-2016, f. & cert. ef. 12-14-16

855-019-0460
Delivery of Care

(1) A pharmacist can prescribe naloxone and the necessary medical supplies for opiate overdose training to an OHA authorized person or organization.

(2) A pharmacist can prescribe naloxone and the necessary medical supplies to an individual who has successfully completed an OHA approved training. The pharmacist shall determine that the individual seeking naloxone demonstrates understanding of educational materials related to opioid overdose prevention, recognition, response, and the administration of naloxone.

(3) The pharmacist may prescribe naloxone in any FDA approved dosage form and the necessary medical supplies needed to administer naloxone.

(4) The pharmacist shall dispense the naloxone product in a properly labeled container identifying the authorized recipient.

(5) Naloxone may not be dispensed without providing oral counseling to the authorized recipient, to include dose, effectiveness, adverse effects, storage conditions, and safety.

(6) The pharmacist must document the encounter and the prescription, and maintain records for three years.

(7) The pharmacy providing naloxone services must establish, maintain, and enforce written procedures including, but not limited to:

(a) Providing a workflow process and physical location that maintains confidentiality and is not susceptible to distraction; and

(b) Documentation and recordkeeping.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305, 689.681 & 2016 OL Ch. 100
Hist.: BP 5-2016(Temp), f. & cert. ef. 9-7-16 thru 3-5-17; BP 6-2016, f. & cert. ef. 12-14-16

855-041-2340
Pharmacist Prescribing of Naloxone

(1) A pharmacist educated in opiate overdose and naloxone rescue may prescribe unit-of-use naloxone and the necessary medical supplies to administer the naloxone to an individual who:

(a) Conducts training that meets that criteria established by the Oregon Health Authority (OHA) so that the person may possess and distribute naloxone and the necessary medical supplies to persons who successfully complete the training; or

(b) Has successfully completed training that meets criteria established by the OHA allowing the person to possess and administer naloxone to any individual who appears to be experiencing an opiate overdose.

(2) The pharmacy providing naloxone services must establish, maintain and enforce written procedures including, but not limited to:

(a) Providing a workflow process and physical location that maintains confidentiality and is not susceptible to distraction; and

(b) Documentation and recordkeeping.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305, 689.681 & 2016 OL Ch. 100
Hist.: BP 5-2016(Temp), f. & cert. ef. 9-7-16 thru 3-5-17; BP 6-2016, f. & cert. ef. 12-14-16

855-080-0021
Schedule I

(1) Schedule I consists of the drugs and other substances, by whatever official, common, usual, chemical, or brand name designated, listed in 21CFR part 1308.11, and unless specifically excepted or unless listed in another schedule, any quantity of the following substances, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

(a) 1,4-butanediol;

(b) Gamma-butyrolactone

(c) Methamphetamine, except as listed in OAR 855-080-0022;

(d) Dichloro-N-(2-(dimethylamino)cyclohexyl)-N-methylbenzamide (U-47700)

(e) 4-chloro-N-[1-[2-(4-nitrophenyl)ethyl]piperidin-2-ylidene]benzenesulfonamide (W-18) and positional isomers thereof, and any substituted derivative of W-18 and its positional isomers, and their salts, by any substitution on the piperidine ring (including replacement of all or part of the nitrophenylethyl group), any substitution on or replacement of the sulfonamide, or any combination of the above that are not FDA approved drugs, unless specifically excepted or when in the possession of an FDA registered manufacturer or a registered research facility, or a person for the purpose of sale to an FDA registered manufacturer or a registered research facility.

(f) Substituted derivatives of cathinone and methcathinone that are not listed in OARs 855-080-0022 through 0026 (Schedules II through V) or are not FDA approved drugs, including but not limited to,

(A) Methylmethcathinone (Mephedrone);

(B) Methylenedioxypyrovalerone (MDPV);

(C) Methylenedioxymethylcathinone (Methylone);

(D) 2-Methylamino-3',4'-(methylenedioxy)-butyrophenone (Butylone);

(E) Fluoromethcathinone (Flephedrone);

(F) 4-Methoxymethcathinone (Methedrone).

(2) Schedule I also includes any compounds in the following structural classes (2a–2k) and their salts, that are not FDA approved drugs, unless specifically excepted or when in the possession of an FDA registered manufacturer or a registered research facility, or a person for the purpose of sale to an FDA registered manufacturer or a registered research facility:

(a) Naphthoylindoles: Any compound containing a 3-(1-naphthoyl)indole structure with substitution at the nitrogen atom of the indole ring whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of this structural class include but are not limited to: JWH-015, JWH-018, JWH-019, JWH-073, JWH-081, JWH-122, JWH-200, JWH-210, AM-1220, MAM-2201 and AM-2201;

(b) Phenylacetylindoles: Any compound containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Examples of this structural class include but are not limited to: JWH-167, JWH -201, JWH-203, JWH-250, JWH-251, JWH-302 and RCS-8;

(c) Benzoylindoles: Any compound containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Examples of this structural class include but are not limited to: RCS-4, AM-694, AM-1241, and AM-2233;

(d) Cyclohexylphenols: Any compound containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring whether or not substituted in the cyclohexyl ring to any extent. Examples of this structural class include but are not limited to: CP 47,497 and its C8 homologue (cannabicyclohexanol);

(e) Naphthylmethylindoles: Any compound containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent;

(f) Naphthoylpyrroles: Any compound containing a 3-(1-naphthoyl) pyrrole structure with substitution at the nitrogen atom of the pyrrole ring whether or not further substituted in the pyrrole ring to any extent and whether or not substituted in the naphthyl ring to any extent;

(g) Naphthylmethylindenes: Any compound containing a 1-(1-naphthylmethyl) indene structure with substitution at the 3-position of the indene ring whether or not further substituted in the indene ring to any extent and whether or not substituted in the naphthyl ring to any extent;

(h) Cyclopropanoylindoles: Any compound containing an 3-(cyclopropylmethanoyl)indole structure with substitution at the nitrogen atom of the indole ring, whether or not further substituted in the indole ring to any extent and whether or not substituted in the cyclopropyl ring to any extent. Examples of this structural class include but are not limited to: UR-144, XLR-11 and A-796,260;

(i) Adamantoylindoles: Any compound containing a 3-(1-adamantoyl)indole structure with substitution at the nitrogen atom of the indole ring, whether or not further substituted in the indole ring to any extent and whether or not substituted in the adamantyl ring to any extent. Examples of this structural class include but are not limited to: AM-1248 and AB-001;

(j) Adamantylindolecarboxamides: Any compound containing an N-adamantyl-1-indole-3-carboxamide with substitution at the nitrogen atom of the indole ring, whether or not further substituted in the indole ring to any extent and whether or not substituted in the adamantyl ring to any extent. Examples of this structural class include but are not limited to: STS-135 and 2NE1; and

(k) Adamantylindazolecarboxamides: Any compound containing an N-adamantyl-1-indazole-3-carboxamide with substitution at the nitrogen atom of the indazole ring, whether or not further substituted in the indazole ring to any extent and whether or not substituted in the adamantyl ring to any extent. Examples of this structural class include but are not limited to: AKB48.

(3) Schedule I also includes any other cannabinoid receptor agonist that is not listed in OARs 855-080-0022 through 0026 (Schedules II through V) or is not an FDA approved drug.

(4) Schedule I also includes any substituted derivatives of fentanyl that are not listed in OARs 855-080-0022 through 0026 (Schedules II through V) or are not FDA approved drugs, and are derived from fentanyl by any substitution on or replacement of the phenethyl group, any substitution on the piperidine ring, any substitution on or replacement of the propanamide group, any substitution on the phenyl group, or any combination of the above.

(5) Exceptions. The following are exceptions to subsection (1) of this rule:

(a) 1, 4-butanediol and gamma-butyrolactone when in the possession of a person for the purpose of its sale to a legitimate manufacturer of industrial products and the person is in compliance with the Drug Enforcement Administration requirements for List I Chemicals;

(b) 1, 4-butanediol and gamma-butyrolactone when in the possession of a person for the purpose of the legitimate manufacture of industrial products;

(c) Marijuana and delta-9-tetrahydrocannabinol (THC).

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 475.035, 475.059 & 475.065
Hist.: PB 4-1987, f. & ef. 3-30-87; PB 8-1987, f. & ef. 9-30-87; PB 10-1987, f. & ef. 12-8-87; PB 15-1989, f. & cert. ef. 12-26-89; PB 9-1990, f. & cert. ef. 12-5-90; PB 5-1991, f. & cert. ef. 9-19-91; PB 1-1992, f. & cert. ef. 1-31-92 (and corrected 2-7-92); PB 1-1994, f. & cert. ef. 2-2-94; PB 1-1996, f. & cert. ef. 4-5-96; PB 1-1997, f. & cert. ef. 9-22-97; BP 4-2000, f. & cert. ef. 2-16-00; BP 9-2000, f. & cert. ef. 6-29-00; BP 2-2002(Temp), f. & cert. ef. 2-4-02 thru 7-31-02; BP 3-2002(Temp), f. & cert. ef. 3-1-02 thru 8-23-02; BP 4-2002, f. 6-27-02, cert. ef. 7-1-02; BP 5-2002, f. & cert. ef. 11-14-02; BP 1-2003, f. & cert. ef. 1-14-03; BP 1-2007, f. & cert. ef. 6-29-07; BP 8-2010, f. & cert. ef. 6-29-10; BP 10-2010(Temp), f. & cert. ef. 10-15-10 thru 4-11-11; BP 2-2011, f. & cert. ef. 4-11-11; BP 9-2013, f. & cert. ef. 10-28-13; BP 11-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; BP 4-2014(Temp), f. 2-27-14, cert. ef. 2-28-14 thru 8-27-14; BP 5-2014(Temp), f. & cert. ef. 4-15-14 thru 8-27-14; BP 7-2014, f. & cert. ef. 6-18-14; BP 3-2016(Temp), f. & cert. ef. 8-22-16 thru 2-17-17; BP 6-2016, f. & cert. ef. 12-14-16

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

Rule Caption: Amendments to rules governing return-to-work incentive programs and vocational assistance
Adm. Order No.: WCD 4-2016
Filed with Sec. of State: 11-28-2016
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Rules Amended: 436-105-0003, 436-105-0005, 436-105-0006, 436-105-0008, 436-105-0500, 436-105-0510, 436-105-0511, 436-105-0512, 436-105-0520, 436-105-0530, 436-105-0540, 436-105-0550, 436-105-0560, 436-110-0003, 436-110-0005, 436-110-0006, 436-110-0007, 436-110-0150, 436-110-0240, 436-110-0290, 436-110-0310, 436-110-0320, 436-110-0325, 436-110-0330, 436-110-0335, 436-110-0336, 436-110-0337, 436-110-0345, 436-110-0346, 436-110-0347, 436-110-0350, 436-110-0351, 436-110-0352, 436-110-0850, 436-110-0900, 436-120-0003, 436-120-0005, 436-120-0008, 436-120-0012, 436-120-0115, 436-120-0145, 436-120-0165, 436-120-0175, 436-120-0185, 436-120-0410, 436-120-0443, 436-120-0445, 436-120-0500, 436-120-0510, 436-120-0520, 436-120-0530, 436-120-0700, 436-120-0710, 436-120-0720, 436-120-0755, 436-120-0800, 436-120-0810, 436-120-0820, 436-120-0840, 436-120-0900, 436-120-0915
Rules Repealed: 436-105-0001, 436-105-0002, 436-110-0001, 436-110-0002, 436-120-0001, 436-120-0002, 436-120-0006, 436-120-0014, 436-120-0016, 436-120-0017, 436-120-0018, 436-120-0125, 436-120-0135, 436-120-0449, 436-120-0830
Rules Ren. & Amend: 436-120-0007 to 436-120-0147, 436-120-0155 to 436-120-0117, 436-120-0340 to 436-120-0157, 436-120-0400 to 436-120-0177, 436-120-0430 to 436-120-0197, 436-120-0448 to 436-120-0523, 436-120-0451 to 436-120-0527, 436-120-0455 to 436-120-0187
Subject: The agency has amended OAR 436-105, "Employer-at-Injury Program" (EAIP) to:

- Improve the clarity of the rules through improved organization, plain language, and definition of terms;
- Clarify the purpose of EAIP assistance;
- Clarify that monies in the Workers' Benefit Fund may not be used to provide concurrent benefits under the Employer-at-Injury Program and the Preferred Worker Program for the same worker for the same period of time, except for reimbursement of claims costs;
- Clarify how parties may request reconsideration if they are directly affected by a decision regarding the EAIP;
- Require that a medical release specify the worker's hourly restrictions if the release is for part-time work or fewer hours than the worker normally worked before the injury;
- Limit the effective period for a medical release to 30 days if the release does not specify an end date or follow-up date, no subsequent medical release is issued, and there is no indication that the worker followed up with the medical service provider;
- Require that all EAIP documentation be prepared and in the insurer's possession before reimbursement is requested from the division;
- More specifically describe what payroll records must include;
- Specify that EAIP eligibility ends when Preferred Worker Program benefits, including premium exemption, (except claim cost reimbursement) begin;
- Clarify that the EAIP may be used only once per worker per claim opening or request for reopening;
- State that modifications and purchases must be ordered before the end of the EAIP;
- Expressly exclude reimbursement for extended warranties for worksite modifications and purchases that are in addition to the standard or manufacturer's warranty;
- Broaden the description of how an insurer must display receipt dates on documentation to accommodate non-physical date stamps and to be consistent with claim processing rules;
- State that if the director finds that procedures that led to disallowed reimbursements are still being used, the director may withhold further reimbursements until corrections satisfactory to the director are made, consistent with language in OAR 436-110; and
- Provide that if there is conflicting documentation regarding eligibility for reimbursement for EAIP services, the director will use a preponderance-of-evidence standard to make its decision, and if there is no clear preponderance, reimbursement will be denied.

The agency has amended OAR 436-110, "Preferred Worker Program" (PWP) to:

- Improve the clarity of the rules through improved organization, plain language, and definition of terms;
- Clarify that monies in the Workers' Benefit Fund may not be used to provide concurrent benefits under the Preferred Worker Program and the Employer-at-Injury Program for the same worker for the same period of time, except for reimbursement of claims costs;
- Clarify how parties may request reconsideration if they are directly affected by a decision of the Workers' Compensation Division regarding the PWP;
- Specify that if a claim disposition agreement is approved before the worker is medically stationary, the insurer must continue to process the claim for purposes of the PWP;
- Explain that work experience program participants, apprentices, and trainees covered under ORS 656.033, 656.046, 656.135, or 656.138, are eligible for the PWP if they otherwise meet the eligibility requirements in the rules, and that the job for which the individual was being trained is regular work;
- Revise the requirements for premium exemption, requiring the employer to notify the division instead of the insurer;
- Require that requests for claim cost reimbursement must be submitted within 15 months of the date on which payment was made;
- More specifically describe what payroll records in support of reimbursement requests must include;
- Place a dollar maximum on wage subsidy for a worker and remove the limit on the number of times wage subsidy may be used unless the worker has an exceptional disability - if so the worker may use wage subsidy twice with no maximum total reimbursement;
- Provide that a worker may use a second wage subsidy with the same employer for a new job if the majority of job duties have changed and at least one year has passed from the end of the first wage subsidy period;
- Increase maximum allowed payments for several categories of employment purchases: tuition, books, and fees; lodging, meals, and mileage; tools and equipment; clothing; occupational certification, licenses, and related testing costs, drug screen testing, physical examinations, or membership fees required for the job; and worksite creation;
- Remove the limits on the number of uses for several categories of employment purchases: tuition, books, and fees; tools and equipment; and clothing;
- Add a new type of employment purchase - transportation-related purchases that enable a worker to commute to a job (does not include vehicles or vehicle maintenance);
- Describe placement services and provide that payment will be made up to a dollar maximum, regardless of whether the worker finds employment, but provide for additional payments if the worker is employed as a result of the services and again if the worker remains in that position for at least 30 days;
- Require that requests for payment for placement services be submitted within one year of the end date of the placement assistance agreement;
- Increase the dollar maximums allowed for worksite modification services and set a per-use cap;
- Increase the dollar maximums allowed for modifications to prevent further injury, rental of worksite modification items, and consultative services;
- For worker-activated worksite modification assistance, remove the limit on the number of times a worker may use the assistance, but limit use to once per employer, unless the job is a new job; and
- Provide that a worker can use a second worksite modification with the same employer for a new job if the majority of the job duties have changed.

The agency has amended OAR 436-120, "Vocational Assistance to Injured Workers" to:

- Improve the clarity of the rules through improved organization, plain language, definition of terms, and removal of obsolete provisions;

- Provide that if the worker returns to work with the employer at injury, the division may verify whether the employment is suitable;

- Clarify procedural requirements for administrative review and resolution of disputes;

- State that all notices and warnings must be copied to the division;

- State that a notice is not effective until it is mailed to all required parties including the worker's legal representative;

- Repeal the rule addressing notification of employment and reinstatement rights and responsibilities, because these statutory provisions are sufficiently described in ORS 656.262, 656.340, and ORS chapter 659A;

- Repeal rules allowing postponement of a worker's vocational eligibility evaluation, and allow deferral in specified circumstances when the employer at injury has activated Preferred Worker Program benefits;

- Remove the definition of "likely eligible" and clarify when an eligibility evaluation is required;

- Clarify that if a worker requests vocational assistance when the insurer is not required to do an eligibility evaluation, the insurer may not deny eligibility;

- Clarify the timeframe for completing an eligibility evaluation, including notifying the worker of the results;

- Allow the counselor to extend the time to complete the eligibility evaluation if the counselor is unable to obtain needed information;

- Include specified circumstances in which the worker does not need to be available in Oregon;

- Explain that work experience program participants, apprentices, and trainees covered under ORS 656.033, 656.046, 656.135, or 656.138, are eligible for vocational assistance if they otherwise meet the eligibility criteria; and define employer at injury, regular employment, and suitable wage for those individuals;

- Clarify the circumstances under which the insurer may end vocational assistance after a worker has been employed in suitable employment due to an employer-at-injury use of the PWP;

- Specify that the insurer and worker must agree on a counselor rather than a vocational assistance provider;

- Require that if the worker and insurer do not agree on a counselor or on a change of counselor, the insurer must notify the division within five days;

- List the responsibilities of the worker and counselor in training and direct employment plans;

- Remove outdated language regarding vocational evaluations;

- Clarify that training may be extended for a worker with an "exceptional loss of earning capacity" if the extension will allow the worker to obtain, at the time of completion of the training program, a wage what is as close as possible to the adjusted weekly wage and greater than could be expected with a shorter program;

- Require that the insurer provide further training to a worker when the initial plan will not be or was not successful to prepare the worker for suitable employment;

- Increase the allowable time (months) for basic education, occupational skills training, and formal training;

- Require the training plan to notify the worker if temporary disability benefits may end before training ends;

- Require the insurer to approve or disapprove a training plan within 14 days;

- Require the insurer to issue a written warning before ending an academic program for specified reasons;

- Require the insurer to pay for approved direct worker purchases within 30 days after the insurer receives the worker's request or proof of payment, whichever is later;

- Remove as factors the insurer may consider in determining the necessity of direct worker purchases: pre-injury net income compared with post-injury net income; family income; and evidence of financial hardship;

- Reduce the time within which an insurer must pay vocational assistance providers' bills for services from 60 to 30 days from receipt; and

- Allow continuing education credits for counselors who teach a class or provide a formal presentation to a group on a topic relating to vocational rehabilitation.

Rules Coordinator: Fred Bruyns—(503) 947-7717

436-105-0003
General Provisions

(1) Purpose.

(a) The rules in OAR 436-105 explain who qualifies for and how to request assistance and reimbursements from the Employer-at-Injury Program.

(b) The Employer-at-Injury Program encourages the early return to work of injured workers by providing incentives from the Workers' Benefit Fund to employers.

(c) The Employer-at-Injury Program is activated by the employer and administered by the insurer.

(d) The purpose of Employer-at-Injury Program assistance is to:

(A) Enable the worker to perform transitional work within the worker's limitations that resulted in the worker's eligibility for the Employer-at-Injury Program;

(B) Prevent a worsening of the worker's compensable injury or occupational disease; or

(C) If the claim has not been accepted or denied, prevent a worsening of the claimed workers' compensation injury or occupational disease.

(2) Applicability. These rules apply to:

(a) All individual employer-at-injury programs started on or after the effective date of these rules, unless otherwise provided in subsections (b) or (c) of this section;

(b) All wage subsidy reimbursement requests when the wage subsidy period began on or after the effective date of these rules; and

(c) All reimbursement requests received by the division on or after the effective date of these rules for worksite modification or program purchases, regardless of when the purchase was made.

(3) Submitting documents or information, calculating time.

(a) Documents or information required under these rules to be submitted to the division may be submitted in any of the following ways:

(A) Mailed to the division's mailing address with sufficient postage and placed in the custody of the U.S. Postal Service;

(B) Physical delivery to the division's Salem office;

(C) Faxed, if the document transmitted indicates it has been delivered by fax, is sent to the correct fax number, and indicates the date it was sent; or

(D) Any other method authorized by the director.

(b) Timeliness under these rules is determined as follows:

(A) If a document is mailed, it will be considered submitted on the date it is postmarked.

(B) If a document is delivered, it must be delivered during regular business hours and marked as received to be considered submitted on that date.

(C) If a document is faxed, it must be received by 11:59 p.m. Pacific Time to be considered submitted on that date.

(c) Time periods allowed under these rules are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(4) Director's discretion. The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2004(Temp), f. 3-22-04, cert. ef. 4-1-04 thru 9-27-04; WCD 8-2004, f. 7-15-04, cert. ef. 8-1-04; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 3-2013, f. 4-12-13, cert. ef. 7-1-13; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0005
Definitions

For the purpose of these rules, unless the context requires otherwise:

(1) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(2) "Department" means the Department of Consumer and Business Services.

(3) "Director" means the director of the Department of Consumer and Business Services, or the director's delegate for the matter.

(4) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(5) "Employer at injury" means the organization that employed the worker when the worker:

(a) Sustained the injury or occupational disease;

(b) Made the claim for aggravation; or

(c) Requested an Own Motion opening under ORS 656.278.

(6) "Insurer" means the insurance company or self-insured employer responsible for the workers' compensation claim.

(7) "Premium" means the monies paid to an insurer for the purpose of purchasing workers' compensation insurance.

(8) "Regular work" means the job the worker held at the time of injury, claim for aggravation, or Own Motion opening under ORS 656.278.

(9) "Skills building" means a class or course of instruction taken by the worker for the purpose of enhancing an existing skill or developing a new skill.

(10) "Transitional work" means temporary work with the employer at injury that is not the worker's full-duty regular work and is assigned because the worker cannot perform full-duty regular work.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0006
Workers' Benefit Fund

(1) The department maintains the financial integrity of the Workers' Benefit Fund under ORS 656.605 and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has the final authority to determine how the funds will be disbursed.

(2) Monies in the Workers' Benefit Fund may not be used to provide concurrent benefits under the Employer-at-Injury Program and the Preferred Worker Program under OAR 436-110 for the same worker for the same period of time, with the exception of claims costs reimbursed under OAR 436-110-0330.

(3) The director may use monies from the Workers' Benefit Fund for activities to provide information about and encourage the re-employment of injured workers. A maximum of $250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

(a) Advertisements and promotion of re-employment assistance programs and associated production costs; and

(b) Public re-employment assistance program conferences and workshops.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0008
Denial of Reimbursement, Reconsideration, Director's Review

(1) Denial of reimbursement. The director will deny any reimbursement for Employer-at-Injury Program assistance it finds violates these rules. The director has the discretion to deny any reimbursement of Employer-at-Injury Program assistance it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Reconsideration.

(a) Parties directly affected by an Employer-at-Injury Program decision may request reconsideration by submitting a written request to the division no later than 60 days after the date the decision was issued.

(b) The request for reconsideration must specify the reasons why the decision is appealed and may include additional documentation.

(c) The director will reconsider the decision and will notify all directly affected parties of its decision upon reconsideration.

(d) Reconsideration must precede a director's review under section (3) of this rule.

(3) Director's review.

(a) Parties affected by the reconsideration may request a director's review by submitting a written request to the division no later than 60 days after the date the reconsideration was issued. The request must specify the reasons why the decision is appealed and may include additional documentation.

(b) The director may require any affected party to provide information or to participate in the director's review. If the party requesting the director's review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(c) The director's review decision will be issued in writing. The director's review decision is final and not subject to further review by any court or other administrative body.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0500
Insurer Participation in the Employer-At-Injury Program

(1) Insurer participation. An insurer must be an active participant in providing re-employment assistance under the Employer-at-Injury Program with the employer's consent. Participation includes issuing notices of the available assistance and administering the Employer-at-Injury Program as specified in these rules.

(2) Notice of assistance available. The insurer must notify the worker and employer at injury in writing of the assistance available from the Employer-at-Injury Program. A notice must be issued:

(a) Upon acceptance or reopening of a claim; and

(b) Within five days of a worker's first release for work after claim opening unless the release is for regular work.

(3) Required notice language.

(a) The notice to the worker required by section (2) of this rule must be in bold type and contain the following language: The Employer-at-Injury Program provides Oregon's qualified injured workers help with staying on the job or getting back to work. Because of your injury, your employer may be eligible for assistance to return you to transitional work through this program while your claim is open. Your employer may contact [insurer name and phone number].

(b) The notice to the employer at injury required by section (2) of this rule must be in bold type and contain the following language: Because of your worker's injury, you may be eligible for assistance through the Employer-at-Injury Program to return the worker to transitional work while the worker's claim is open. To learn more about the assistance available from the program, please call [insurer name and phone number].

(4) Insurer administration of program. The insurer must administer the Employer-at-Injury Program according to these rules. The insurer must assist an employer to:

(a) Obtain from the medical service provider a medical release that meets the requirements of section (5) of this rule;

(b) Identify a transitional work position:

(A) The transitional work position must be within the worker's injury-caused limitations and may be created through modification of the worker's regular work, job restructuring, assistive devices, worksite modification, reduced hours, or reassignment to another job;

(B) Unless the transitional work is skills building, the position must be within the employer's course and scope of trade or profession; and

(C) When skills building is the transitional work, the worker must agree in writing to take the class or course of instruction;

(c) Process employer wage subsidy requests as specified in OAR 436-105-0520(2);

(d) Make worksite modification purchases as specified in OAR 436-105-0520(3);

(e) Make Employer-at-Injury Program purchases as specified in OAR 436-105-0520(4); and

(f) Request Employer-at-Injury Program reimbursement from the division as specified in OAR 436-105-0540.

(5) Medical releases.

(a) Medical releases are required for purposes of the Employer-at-Injury Program.

(b) A medical release must be related to the compensable injury or occupational disease or, if the claim has not been accepted or denied, the claimed workers' compensation injury or occupational disease.

(c) A medical release must:

(A) State the worker's specific current or projected restrictions; or

(B) Indicate the worker is not released to regular work and be accompanied by an approval of a job description that includes the job duties and physical demands required for the transitional work.

(d) A medical release that releases the worker to part-time work or fewer hours than the worker normally worked before the injury must specify the worker's hourly restrictions.

(e) A medical release must be dated and cover any period of time for which benefits are requested.

(A) The date a medical release is issued is considered the effective date if an effective date is not otherwise specified.

(B) A medical release, and any restrictions it contains, remains in effect until another medical release is issued.

(C) If a medical release does not specify an end date or follow-up date and no subsequent medical release is issued, and there is no indication that the worker followed up with the medical service provider, the medical release is effective for no more than 30 days.

(f) An employer or insurer may get clarification about a medical release from the medical service provider who issued the release any time before submitting the reimbursement request.

(6) Required documentation. The insurer must maintain all records and documentation of the Employer-at-Injury Program for a period of three years from the date of the last Employer-at-Injury Program reimbursement request. All documentation must be prepared before reimbursement is requested from the division. The insurer must maintain the following information at an authorized claim processing location:

(a) The worker's claim file;

(b) Documentation from the worker's medical service provider that the worker is unable to perform regular work due to the injury and dated copies of all work releases from the worker's medical service provider;

(c) Documentation of the transitional work that includes the start date, wage and hours, and a description of the job duties;

(d) A legible copy of the worker's payroll records for the wage subsidy period.

(A) Payroll records must include:

(i) The date of payment;

(ii) The dates of work covered by the payment;

(iii) The rate or rates of pay;

(iv) Gross wages;

(v) Whether the worker is paid by the hour, shift, day, or week or on a salary, piece, or commission basis;

(vi) The regular hourly rate or rates of pay, the number of regular hours worked, and pay for those hours;

(vii) The number of overtime hours worked, if any, and pay for those hours; and

(viii) The overtime rate or rates of pay;

(B) Payroll records may be supplemented with documentation of how the worker's earnings were calculated for the wage subsidy. Supplemental documentation may be used to determine a worker's work schedule, wages earned on a particular day, dates of paid leave, or to clarify any other necessary information not fully explained by the payroll record;

(e) Documentation of the time of the appointment and hours and wages of transitional work for any days for which a partial day's reimbursement is requested after the worker is released for transitional work, or before returning from a medical appointment with a regular work release;

(f) A legible copy of proof of purchase, providing proof the item was ordered during the Employer-at-Injury Program period and proof of payment of the items for worksite modification purchases and Employer-at-Injury Program purchases;

(g) Documentation of the insurer's approval of worksite modifications;

(h) Documentation that payments for a home care worker were made to the Oregon Department of Human Services or Oregon Health Authority, if applicable;

(i) Written acceptance by the worker when skills building is the transitional work; and

(j) Documentation, including course title and curriculum for a class or course of instruction, when Employer-at Injury Program purchases are requested.

Stat. Auth.: ORS 656.622 & 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0090; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0360; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0540; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2004(Temp), f. 3-22-04, cert. ef. 4-1-04 thru 9-27-04; WCD 8-2004, f. 7-15-04, cert. ef. 8-1-04; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 1-2015, f. 1-29-15, cert. ef. 3-1-15; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0510

Employer Eligibility

To be eligible for the Employer-at-Injury Program, an employer must:

(1) Maintain Oregon workers' compensation insurance coverage;

(2) Be the employer at injury; and

(3) Employ an eligible worker.

Stat. Auth.: ORS 656.622, 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78, WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0020, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0020; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered to 436-110-0280; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0520; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0511

Worker Eligibility

To be eligible for the Employer-at-Injury Program, a worker must:

(1) Have an Oregon workers' compensation injury or occupational disease claim at the time of the Employer-at-Injury Program; and

(2) Not be covered as an injured inmate under ORS 655.505 to 655.555 and OAR 125-160.

Stat. Auth.: ORS 656.622, 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78, WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0020, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0020; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered to 436-110-0280; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0520; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; Renumbered from 436-105-0510, WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0512

End of Eligibility

Employer-at-Injury Program eligibility ends:

(1) When the worker or employer no longer meets the eligibility provisions stated in OAR 436-105-0510 and 436-105-0511;

(2) When the worker's claim is closed or denied;

(3) When sanctions issued under OAR 436-105-0560 preclude eligibility;

(4) When the insurer ends the Employer-at-Injury Program at any time while the worker's claim is open;

(5) Two years after the original date of acceptance of a nondisabling claim; or

(6) When benefits under the Preferred Worker Program under OAR 436-110 begin, including premium exemption but excluding claims costs reimbursed under OAR 436-110-0330.

Stat. Auth.: ORS 656.622, 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78, WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0020, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0020; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered to 436-110-0280; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0520; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; Renumbered from 436-105-0510, WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0520

Assistance Available from the Employer-at-Injury Program

(1) General provisions.

(a) The Employer-at-Injury Program may be used only once per worker per claim opening or request for reopening. If a nondisabling claim becomes a disabling claim after one year from the date of acceptance, the disabling claim is considered a new opening and the Employer-at-Injury Program may be used again.

(b) Assistance available includes wage subsidy, worksite modification, and purchases.

(c) Any modification and other purchases must be ordered before the end of the Employer-at-Injury Program.

(2) Wage subsidy. Wage subsidy provides reimbursement of 45 percent of the worker's gross wages for the wage subsidy period. Wage subsidy benefits are subject to the following conditions:

(a) A wage subsidy may not exceed 66 workdays and must be completed within a 24-consecutive month period;

(b) A wage subsidy may not start or end with paid leave;

(c) If the worker has hourly restrictions, reimbursable paid leave cannot exceed the maximum number of hours of the worker's hourly restrictions. Paid leave exceeding the worker's hourly restrictions will not be reimbursed; and

(d) Any day during which the worker exceeds his or her injury-caused limitations will not be reimbursed. If, however, an employer uses a time clock, a reasonable time of up to 30 minutes per day will be allowed for the worker to get to and from the time clock and the worksite without exceeding the worker's hourly restrictions.

(3) Worksite modification.

(a) Worksite modification is altering a worksite by renting, purchasing, modifying, or supplementing equipment to:

(A) Enable a worker to perform the transitional work within the worker's limitations that resulted in the worker's Employer-at-Injury Program eligibility;

(B) Prevent a worsening of the worker's compensable injury or occupational disease; or

(C) If the claim has not been accepted or denied, to prevent a worsening of the claimed workers' compensation injury or occupational disease.

(b) For purposes of the Employer-at-Injury Program, a "worksite" is a primary work area available for a worker to use to perform the required job duties. The worksite may be the employer's, client's, or worker's premises, property, or equipment used to conduct business under the employer's or client's direction and control. A worksite may include a worker's personal property or vehicle if required to perform the job.

(c) Worksite modification assistance is subject to the following conditions:

(A) The insurer must determine the appropriate worksite modifications for the worker;

(B) The insurer must document its reasons for approving the modifications; and

(C) Worksite modification items become the employer's property at the end of the Employer-at-Injury Program.

(4) Employer-at-Injury Program purchases. Employer-at-Injury Program purchases are limited to:

(a) Tuition, books, fees, and materials required for skills building or to meet the requirements of the transitional work position. Maximum expenditure is $1,000. Tuition, books, fees, and required materials will be provided under the following conditions:

(A) The insurer must determine the class or course of instruction will help the worker enhance an existing skill or develop a new skill, and must document its decision; and

(B) The worker must begin participation in the class or course of instruction while eligible for the Employer-at-Injury Program;

(b) Clothing required for the job, except clothing the employer normally provides. Clothing becomes the worker's property. Maximum expenditure is $400; and

(c) Tools and equipment required for the worker to perform transitional work, including consumables required to support the functioning of the tools or equipment. These purchases become the employer's property.

(5) Other conditions for worksite modifications and purchases.

(a) Worksite modification and purchases of tools and equipment are limited to a combined maximum reimbursement of $5,000.

(b) Extended warranties that are in addition to the standard or manufacturer's warranty are not reimbursable under the Employer-at-Injury Program.

(c) All modifications and purchases made by the employer in good faith are reimbursable, even if the worker refuses to return to work, or if the worker agreed to take part in training and then later refused to attend training.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0041, 436-110-0042 & 436-110-0045; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0510; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 3-2013, f. 4-12-13, cert. ef. 7-1-13; WCD 1-2015, f. 1-29-15, cert. ef. 3-1-15; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0530
Employer-at-Injury Program Procedures for Concurrent Injuries

(1) A worker is eligible for only one Employer-at-Injury Program at a time.

(2) When a worker in an Employer-at-Injury Program incurs a new compensable injury, transitional work for the first Employer-at-Injury Program is considered regular work for purposes of the second Employer-at-Injury Program.

(3) If the new injury makes the first Employer-at-Injury Program unsuitable, the worker may be eligible for a second Employer-at-Injury Program under the new injury.

(4) When the worker is no longer eligible for the second Employer-at-Injury Program, the first Employer-at-Injury Program may be resumed if the employer and worker still meet eligibility criteria under that claim.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0540
Employer-at-Injury Program Reimbursement Procedures

The following provisions apply when the insurer requests reimbursement from the division under the Employer-at-Injury Program:

(1) Reimbursable benefits. Reimbursements may include wage subsidy, Employer-at-Injury Program purchases, and worksite modification.

(2) Program administrative costs. The insurer is entitled to a program administrative cost of $120 for the first approved reimbursement request for an Employer-at-Injury Program. Subsequent requests for reimbursement, including amended requests, for the same Employer-at-Injury Program are not entitled to additional program administrative costs.

(3) Minimum reimbursement request. The first reimbursement request for an Employer-at-Injury Program must be for a minimum of $100. Subsequent requests, including amended requests, may be for less than $100.

(4) Required documentation. The insurer must have all documentation required for reimbursement in its possession at the time reimbursement is requested. The insurer must stamp or display evidence of the initial date of receipt on each document as required under OAR 436-060-0017(2).

(5) Timeframe for submitting request form. The insurer must submit Form 2360, "Employer-at-Injury Program (EAIP) Reimbursement Request Form," to the division within one year and 30 days from the end of the Employer-at-Injury Program. The form is published with Bulletin 260, both of which are available on the division's website at wcd.oregon.gov.

(6) Corrected request forms. If the reimbursement request form is incomplete or contains an error, the division may return the form to the insurer for correction. The insurer has 60 days from the date it receives the returned reimbursement request form from the division, or one year and 30 days from the end of Employer-at-Injury Program eligibility, whichever is later, to make the corrections and return the corrected form to the division.

(7) Amended requests.

(a) Amended reimbursement requests must be submitted to the division within one year and 30 days from the end of the Employer-at-Injury Program eligibility except as otherwise permitted in this rule.

(b) An amended reimbursement request must clearly state that it is an amendment and clearly state the corrected information.

(8) Denied claims.

(a) The insurer may request reimbursement when a claim that was initially denied is subsequently accepted after the Employer-at-Injury Program eligibility ended and more than one year and 30 days have passed. In that case, the insurer must submit a completed Form 2360, "Employer-at-Injury Program (EAIP) Reimbursement Request Form," (published with Bulletin 260, available on the division's website at wcd.oregon.gov) to the division within 60 days of the first litigation order or stipulation and order accepting the claim. A copy of the order or stipulation must be attached to the reimbursement request form.

(b) The insurer may request reimbursement for a qualifying Employer-at-Injury Program that took place before a claim denial even if the claim is denied at the time the insurer submits the request to the division.

(9) Effect on rates, dividends, premiums, or assessments. The insurer may not use Employer-at-Injury Program costs subject to reimbursement for rate making, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments under ORS 656.612 and OAR 436-085 with the present or a future insurer. The insurer must be able to document that Employer-at-Injury Program costs do not affect the employer's rates or dividend.

(10) Claim costs. If a preferred worker employed by an eligible employer with active premium exemption under OAR 436-110-0325 incurs a new injury, the claim is subject to claim costs reimbursement under OAR 436-110-0330. If the worker subsequently begins an Employer-at-Injury Program, program costs must be separated from claim costs and will not be reimbursed as claim costs.

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

Stat. Auth.: ORS 656.622 & 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0090; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0360; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0540; WCD 4-2004(Temp), f. 3-22-04, cert. ef. 4-1-04 thru 9-27-04; WCD 8-2004, f. 7-15-04, cert. ef. 8-1-04; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0550
Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the director. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the director directly or from future reimbursements by way of offset. If the director finds upon audit that procedures that led to disallowed reimbursements are still being used, the director may withhold further reimbursements until corrections satisfactory to the director are made.

(2) An audit may include but not be limited to a review of the records required in OAR 436-105-0500(6).

(3) When there is conflicting documentation, the director will use a preponderance of evidence standard to decide eligibility for reimbursement. If there is no clear preponderance, reimbursement will be denied.

(4) The director reserves the right to visit the worksite to determine compliance with these rules.

Stat. Auth.: ORS 656.455, 656.622, 656.726(4) & 731.475

Stats. Implemented: ORS 656.455, 656.622 & 731.475

Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-105-0560
Sanctions

(1) Penalties for false statement or report or misrepresentation. Any person who knowingly makes a false statement or misrepresentation to the director or an employee of the director for the purpose of obtaining any benefits or reimbursement from the Employer-at-Injury Program, or who knowingly misrepresents the amount of a payroll or knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for sanction. Reasons for the director to sanction an insurer, self-insured employer, employer, or their representative include, but are not limited to:

(a) Misrepresenting information in order to receive Employer-at-Injury Program assistance;

(b) Making a serious error or omission that resulted in the director approving reimbursement in error;

(c) Failing to respond to employer requests for assistance or failing to administer Employer-at-Injury Program assistance; or

(d) Failing to comply with any condition in these rules.

(3) Possible sanctions. The director may order one or more of the following sanctions:

(a) Ordering the person to take corrective action within a specific period of time;

(b) Ordering the person being sanctioned to repay the department all, or part, of the monies reimbursed, with or without interest at a rate set by the department. The order may include the department's legal costs;

(c) Ending the employer's eligibility to use the Employer-at-Injury Program for a specific period of time; or

(d) Pursuing civil penalties under ORS 656.745 or criminal action against the party.

Stat. Auth.: ORS 656.622 & 656.726(4)

Stats. Implemented: ORS 656.622, 656.745 & 656.990

Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0003
Purpose and Applicability of These Rules

(1) Purpose.

(a) The rules in OAR 436-110 explain who qualifies for and how to request assistance and reimbursements from the Preferred Worker Program.

(b) The Preferred Worker Program encourages the re-employment of workers whose on-the-job injuries result in disability that may be a substantial obstacle to employment by providing assistance from the Workers' Benefit Fund to eligible injured workers and to the employers who employ them.

(c) The Preferred Worker Program is activated by the worker or by the employer at injury.

(2) Applicability. These rules apply to all requests for Preferred Worker Program re-employment assistance received by the division on or after the effective date of these rules.

(3) Submitting documents or information, calculating time.

(a) Documents or information required under these rules to be submitted to the division may be submitted in any of the following ways:

(A) Mailed to the division's mailing address with sufficient postage and placed in the custody of the U.S. Postal Service;

(B) Physical delivery to the division's Salem office;

(C) Faxed, if the document transmitted indicates it has been delivered by fax, is sent to the correct fax number, and indicates the date it was sent; or

(D) Any other method authorized by the director.

(b) Timeliness under these rules is determined as follows:

(A) If a document is mailed, it will be considered submitted on the date it is postmarked.

(B) If a document is delivered, it must be delivered during regular business hours and marked as received to be considered submitted on that date.

(C) If a document is faxed, it must be received by 11:59 p.m. Pacific Time to be considered submitted on that date.

(c) Time periods allowed under these rules are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(4) Availability of forms. The bulletins and forms referenced in these rules are available on the division's website at wcd.oregon.gov.

(5) Director's discretion. The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.622 & 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0005, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef.1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0005
Definitions

For the purpose of these rules, unless the context requires otherwise:

(1) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(2) "Date of eligibility" means the date the director determines a worker is a preferred worker.

(3) "Date of hire" means the date the worker starts work as a preferred worker.

(4) "Department" means the Department of Consumer and Business Services.

(5) "Director" means the director of the Department of Consumer and Business Services, or the director's delegate for the matter.

(6) "Disability" means a permanent physical or mental restriction or limitation caused by an accepted disabling Oregon workers' compensation claim that limits the worker from performing one or more of the worker's regular job duties.

(7) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(8) "Employer at injury" means the organization that employed the worker when the worker sustained the injury or occupational disease.

(9) "Exceptional disability" means a disability equal to or greater than the complete loss, or loss of use, of both legs or a brain injury that results in impairment equal to or greater than a Class 3 under OAR 436-035-

0390(10). The director determines whether a worker has an exceptional disability based upon the combined effects of all of the worker's Oregon compensable injuries resulting in permanent disability.

(10) "Fund" means the Workers' Benefit Fund under ORS 656.605.

(11) "Insurer" means the insurance company or self-insured employer responsible for the workers' compensation claim.

(12) "Premium" means the monies paid to an insurer for the purpose of purchasing workers' compensation insurance.

(13) "Premium assessment" means monies due the director under ORS 656.612 and 656.614.

(14) "Regular work" means the job the worker held at the time of the injury, claim for aggravation, or Own Motion opening under ORS 656.278.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0010, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0006
Workers' Benefit Fund

(1) The department maintains the financial integrity of the fund and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has final authority to determine how the funds will be disbursed.

(2) Monies in the Workers' Benefit Fund may not be used to provide concurrent benefits under the Preferred Worker Program and the Employer-at-Injury Program under OAR 436-105 for the same worker for the same period of time, with the exception of claims costs reimbursed under OAR 436-110-0330.

(3) The director may use monies from the fund for activities to provide information about and encourage re-employment of injured workers. A maximum of $250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

(a) Advertisements and promotion of re-employment assistance programs and associated production costs; and

(b) Public re-employment assistance program conferences and workshops.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0015; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0007
Denial of Requests, Reconsideration, Director's Review

(1) Denial of requests for assistance. The director will deny any request for Preferred Worker Program assistance it finds violates these rules. The director has the discretion to deny a request it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Reconsideration.

(a) Parties directly affected by a Preferred Worker Program decision of the director may request reconsideration by submitting a written request to the division no later than 60 days after the date the decision was issued.

(b) The request for reconsideration must specify the reasons why the decision is appealed and may include additional documentation.

(c) The director will reconsider the decision and will notify all directly affected parties of its decision upon reconsideration.

(d) Reconsideration must precede a director's review under section (3) of this rule.

(3) Director's review.

(a) If, upon reconsideration, the director upholds the original decision, it will be referred for director's review. A party does not need to request director's review.

(b) The director may require any affected party to provide information or to participate in the director's review. If the party requesting the director's review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(c) The director's review decision will be issued in writing. The director's review decision is final and not subject to further review by any court or other administrative body.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0080 & 436-110-0090; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0360; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0540; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0150
Pilot Projects

(1) The director may develop one or more pilot projects to test alternatives to the current system of re-employing preferred workers.

(2) Notwithstanding any other provision of these rules, the director and others participating in pilot projects are bound by the terms of the pilot project.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 4-2013, f. 6-5-13, cert. ef. 6-7-13; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0240
Insurer Participation in the Preferred Worker Program

(1) Insurer participation. The insurer of the employer at injury must be an active participant in providing re-employment assistance under the Preferred Worker Program.

(2) Notice of assistance available. The insurer must notify the worker and employer at injury in writing of the assistance available from the Preferred Worker Program. A notice must be issued:

(a) Within five days of the worker being declared medically stationary;

(b) Upon determination of the worker's eligibility or ineligibility for vocational assistance under ORS 656.340 and OAR 436-120; and

(c) Upon approval of a claim disposition agreement.

(3) Required notice language.

(a) The notice to the worker required by section (2) of this rule must be in bold type and contain the following language:

The Preferred Worker Program helps Oregon's injured workers get back to work. To find out whether you qualify, contact the Preferred Worker Program. Call: 503-947-7588 or 800-445-3948 (toll-free) Fax: 503-947-7581
Or write the Preferred Worker Program at P.O. Box 14480, Salem, Oregon 97309-0405 or pwp.oregon@oregon.gov

(b) The notice to the employer at injury required by section (2) of this rule must be in bold type and contain the following language:

As the employer of an injured worker, you may be eligible for valuable Preferred Worker Program incentives if the worker cannot return to regular work and has permanent restrictions caused by the injury.
If the worker's Preferred Worker Program eligibility has not been determined, you may contact the Workers' Compensation Division for an eligibility review.
To be eligible for exemption from paying workers' compensation premiums for this worker for three years, you must:
Bring back your preferred worker to a new or modified job; and
Notify the Workers' Compensation Division within 90 days of the date the worker is determined eligible or within 90 days of the date you bring the worker back to work, whichever is later.
To request all other Preferred Worker Program benefits, you must contact the Workers' Compensation Division within 180 days of the worker's claim closure date.
To find out more about the Preferred Worker Program, contact the program.
Call: 503-947-7588 or 800-445-3948 (toll-free)
Fax: 503-947-7581
Or write the Preferred Worker Program at P.O. Box 14480, Salem, Oregon 97309-0405 or pwp.oregon@oregon.gov

(4) Reporting information to the division. The insurer must provide the division with preferred worker information upon the following:

(a) Claim closure according to ORS 656.268, by submitting Form 1503, "Insurer Notice of Closure Summary," as prescribed by OAR 436-030-0015(1);

(b) Within 30 calendar days of an order on reconsideration, opinion and order of an administrative law judge, order on review by the board, decision of the Court of Appeals or Supreme Court, or stipulation between the parties that grants initial permanent disability after the latest opening of the worker's claim; and

(c) Approval of a claim disposition agreement, if documented medical evidence indicates permanent restrictions exist as a result of the injury or disease, and the worker is unable to return to regular work. If a claim disposition agreement is approved before the worker is medically stationary, the insurer must continue to process the claim to medically stationary for purposes of the Preferred Worker Program.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 656.340, 656.622 & 656.726(4)
Stats. Implemented: ORS 656.340(1), (2), (3), 656.622 & 656.726(4)

Hist.: WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0017; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 1-2010(Temp), f. & cert. ef. 4-15-10 thru 10-11-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0290
Employer at Injury Use of the Preferred Worker Program

The conditions for the employer at injury to activate the Preferred Worker Program are:

(1) Time frame.

(a) For Preferred Worker Program assistance other than premium exemption, the employer at injury must request Preferred Worker Program assistance from the division within 180 days of the worker's claim closure date, except as provided in subsection (1)(c).

(b) Conditions for employer at injury activated premium exemption are provided in OAR 436-110-0325.

(c) When worksite modifications are provided, and the modifications are completed and verified by the director more than 150 days after the worker's claim closure date, the employer at injury will have 30 calendar days from the verification date to request other assistance.

(2) Job offer. The worker must agree to accept the new or modified regular job with the employer at injury in writing. Form 4903, "Preferred Worker Job Offer Letter," is a sample job offer letter. The job offer must include:

(a) The start date, which is the date the worker begins receiving payment for the new or modified job. If the job starts after the modifications are in place, so note;

(b) Wage and hours;

(c) Job site location; and

(d) Description of job duties that includes physical requirements.

(3) Additional modifications. If the employer at injury uses worksite modification assistance and the employer or worker later requests additional modifications for the same job, the employer at injury's worksite modification benefit will be exhausted before using the worker's worksite modification benefits.

Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 1-2010(Temp), f. & cert. ef. 4-15-10 thru 10-11-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0310
Eligibility and End of Eligibility for the Preferred Worker Program

(1) Employer eligibility. The eligibility requirements for the Preferred Worker Program for an employer, including the employer at injury, except as provided in OAR 436-110-0345(1) for employment purchases, are:

(a) The employer has and maintains Oregon workers' compensation insurance coverage;

(b) The employer complies with the Oregon workers' compensation law;

(c) The employer must offer or provide employment to an eligible preferred worker who is a subject Oregon worker according to ORS 656.027;

(d) If the employer is a worker leasing company, it must be licensed with the director under ORS 656.850; and

(e) The employer is not currently ineligible for preferred worker benefits under OAR 436-110-0900.

(2) Worker eligibility. The eligibility requirements for a worker for the Preferred Worker Program are:

(a) The worker has an accepted disabling Oregon compensable injury or occupational disease. Injuries to inmates covered under ORS 655.505 to 655.555 and OAR 125-160 do not qualify;

(b) The worker will not be able to return to regular work, as indicated by medical evidence and due to injury-caused restrictions, under any claim opening;

(c) Medical documentation indicates permanent restrictions exist as a result of the injury or disease, whether or not an order has been issued awarding permanent disability;

(d) The worker is authorized to work in the United States; and

(e) The worker complies with the Oregon workers' compensation law.

(3) Work experience program participants, apprentices, and trainees.

(a) Individuals covered under ORS 656.033, 656.046, 656.135, or 656.138, are eligible for the Preferred Worker Program if they otherwise meet the eligibility requirements in section (2) of this rule.

(b) For purposes of the Preferred Worker Program, for individuals covered under ORS 656.033, 656.046, 656.135, or 656.138, the job for which the individual was being trained is considered regular work.

(4) Self-employment. A worker may not use preferred worker benefits for self-employment unless the injury that gave rise to the worker's eligibility for the Preferred Worker Program occurred in the course and scope of self-employment. In that case, the worker may use the benefits to return to the same self-employment or for employment other than self-employment.

(5) Ending eligibility. Reasons for ending Preferred Worker Program eligibility include, but are not limited to, the following:

(a) Misrepresentation or omission of information by a worker or employer to obtain assistance;

(b) Failure of a worker or employer to provide requested information or cooperate;

(c) Falsification or alteration of a preferred worker card or a Preferred Worker Program agreement;

(d) Conviction of fraud in obtaining workers' compensation benefits;

(e) The worker no longer meets the eligibility requirements under section (2) of this rule; or

(f) The employer no longer meets the eligibility requirements under section (1) of this rule.

(6) Reinstatement of eligibility. The director retains the right to reinstate Preferred Worker Program eligibility if eligibility was ended prematurely or in error, or if the employer has reinstated or obtained workers' compensation insurance coverage.

(7) Redetermination of eligibility. A worker found ineligible because the worker was not authorized to work in the United States may request a redetermination of eligibility after providing the division with documentation that the worker is authorized to work in the United States.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78, WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0020, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0020; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0280; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0320
Preferred Worker Card

(1) The division will issue a preferred worker card to eligible workers. The card identifies a worker as being eligible to offer an employer Preferred Worker Program assistance.

(2) The division will issue a preferred worker card:

(a) Automatically at the time of claim closure based upon insurer submission of preferred worker information as specified in OAR 436-110-0240(4)(a); or

(b) When the division determines the worker is eligible for the Preferred Worker Program.

(3) The division may inactivate a preferred worker card if:

(a) The card was issued in error; or

(b) Any reason for ending Preferred Worker Program eligibility as specified in OAR 436-110-0310(5) applies.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0022; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0325
Premium Exemption

(1) General provisions.

(a) The purpose of premium exemption is to provide an incentive for employers to hire and retain preferred workers.

(b) Premium exemption releases an employer from paying workers' compensation insurance premiums and premium assessments on a preferred worker for three years from the date premium exemption started. When premium exemption is in place, the employer does not report, and the insurer may not use, the preferred worker's payroll for the calculation of insurance premiums or premium assessments. However, the employer must report and pay the Workers' Benefit Fund assessment and withhold employ-

ee contributions as required by ORS 656.506 and OAR 436-070. The employer must start paying insurance premiums and premium assessments when premium exemption ends.

(2) Employer eligibility. To be eligible for premium exemption the employer must:

(a) Hire a preferred worker or, for the employer at injury or aggravation, bring back its preferred worker to a new or modified job; and

(b) Notify the division within 90 days from the date of eligibility or the date of hire, whichever is later.

(3) Exclusion. Premium exemption may not be used if the worker has permanent restrictions but returns to regular work.

(4) Division notification.

(a) The employer must notify the division within 90 days from the date of eligibility or the date of hire, whichever is later.

(b) If the director approves premium exemption, the division will notify the employer and insurer of the premium exemption period.

(c) If the director does not approve premium exemption, the division will notify the employer.

(5) Premium exemption period.

(a) For the employer at injury or aggravation, premium exemption starts on the date of hire or the date of eligibility, whichever is later.

(b) If the employer is not the employer at injury or aggravation, the worker discloses preferred worker status to that employer, and the employer notifies the division within 90 days from the date of hire that it has hired a preferred worker, premium exemption starts on the date of hire.

(c) The three-year premium exemption period may not be extended, even if the preferred worker's job duties change or the employer's ownership or legal status changes.

(6) Claims costs. If a worker covered under premium exemption incurs a compensable injury or occupational disease during the premium exemption period, the employer must notify its insurer of the injury and the worker's preferred worker status. The claim costs for the injury are reimbursed under OAR 436-110-0330.

Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015 & 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 4367-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300 & 436-110-0340; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0330
Claim Cost Reimbursement

(1) General provisions. Claim cost reimbursement provides reimbursement to the insurer for claim costs when a preferred worker files a claim for injury or occupational disease while employed under premium exemption as follows:

(a) Reimbursements will be made for the life of the claim;

(b) Reimbursable claim costs include disability benefits, medical benefits, vocational costs under OAR 436-120-0720, claim disposition agreements under ORS 656.236, disputed claim settlements under ORS 656.289, stipulations, attorney fees awarded the worker or the worker's beneficiaries, and administrative costs;

(c) Reimbursable claim costs for denied claims include costs incurred up to the date of denial, but are limited to benefits the insurer is obligated to pay under ORS chapter 656 and diagnostic tests, including independent medical examinations necessary to determine compensability of the claim;

(d) The administrative cost factor that will apply to claim costs is published in Bulletin 316; and

(e) The claim may not be used for ratemaking, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that claim data will not affect the employer's rates or dividend.

(2) Reimbursement request process. The insurer must request claim cost reimbursement as follows:

(a) A request for reimbursement must be submitted to the division within 15 months of the date on which payment was made;

(b) The insurer must use Form 3014, "Preferred Worker Program Quarterly Cost Reimbursement Request"; and

(c) Reimbursement documentation must include, but is not limited to:

(A) Net amounts paid. "Net amounts" means the total compensation paid less any recoveries, including, but not limited to, third-party recovery or reimbursement from the Retroactive Program, Reopened Claims Program, or the fund; and

(B) Any other information required by the director.

(3) Costs not reimbursable. Requests for reimbursement may not include:

(a) Claim costs for any injury that did not occur while the worker was employed with premium exemption;

(b) Costs incurred for conditions completely unrelated to the compensable claim;

(c) Costs incurred due to inaccurate, untimely, unreasonable, or improper processing of the claim;

(d) Penalties, fines, or filing fees;

(e) Disposition amounts in accordance with ORS 656.236 or 656.289 not previously approved by the director;

(f) Costs reimbursed or outstanding requests for reimbursement from the Reopened Claims Program, Retroactive Program, or the fund; or

(g) Reimbursable Employer-at-Injury Program costs.

(4) Audit, disallowed amounts. Periodically, the director will audit the insurer's file to validate the amount reimbursed. Reimbursed amounts must be refunded to the division and, as applicable, future reimbursements will be denied if, upon audit, any of the following is found to apply:

(a) Reimbursement has been made for any of the items specified in section (3) of this rule;

(b) If claim acceptance as a new injury rather than an aggravation is questionable and the rationale for acceptance has not been reasonably documented;

(c) The separate payments of compensation have not been documented;

(d) The insurer included claim costs in any dividend or retrospective rating or experience rating calculations; or

(e) The insurer is unable to provide applicable records relating to experience rating, retrospective rating, or dividend calculations at the time of audit or within 14 working days thereafter.

(5) Reinstatement of reimbursement. If the conditions described in subsections (4)(a) through (e) of this rule are corrected and all other criteria of the rules are met, eligibility for reimbursement may be reinstated. If reimbursement eligibility is reinstated, any monies previously reimbursed and then recovered will be reimbursed again according to these rules.

(6) Reimbursement of settlement amounts. A claim disposition agreement under ORS 656.236, a disputed claim settlement under ORS 656.289, or any stipulation or agreement of a claim subject to claim cost reimbursement from the fund must meet the following requirements for reimbursement:

(a) The insurer must obtain prior written approval of the agreement from the director. The proposed agreement must be submitted to the division before being submitted to the Workers' Compensation Board or administrative law judge for approval;

(b) A claim's future liability and the proposed contribution from the fund must be a reasonable projection, as determined by the director, in order to be approved for reimbursement from the fund; and

(c) A request for approval of the proposed agreement must include:

(A) A copy of the proposed agreement, containing appropriate signatures and a signature line for director approval, that specifies the proposed assistance from the fund;

(B) A written explanation of how the calculations for the amount of assistance from the fund were made; and

(C) Other information as required by the director.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015, 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 436-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0260 & 436-110-0300; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0335
Wage Subsidy General Provisions

Wage subsidy provides an employer with partial reimbursement of a worker's gross wages for a specified period. Wage subsidy benefits are subject to the following conditions:

(1) Wage subsidy agreement form. A completed Form 2190, "Preferred Worker Wage Subsidy Agreement," must be submitted to the division. Signature and time frame requirements for employer at injury activated wage subsidy are in OAR 436-110-0336(2), and requirements for worker-activated wage subsidy are in OAR 436-110-0337(1).

(2) Effective date. The effective date of the wage subsidy agreement is mutually agreed to by the director, employer, and worker if applicable.

(3) Time limits, reimbursement rate. A wage subsidy is limited to a duration of 183 calendar days and a reimbursement rate of 50 percent for the approved period. For a worker with an exceptional disability, a wage subsidy duration is limited to 365 calendar days and a reimbursement rate of 75 percent for the approved period.

(4) Interruption and extension of agreement. A wage subsidy agreement may be interrupted once for reasonable cause and extended to complete the agreement on a whole workday basis. Reasonable cause includes, but is not limited to, personal or family illness, death in the worker's family, pregnancy of the worker or worker's spouse, a compensable injury to the worker, participation in an Employer-at-Injury Program, or layoff. A layoff must be a minimum of 10 consecutive work days. A period of time during which the employer is without workers' compensation insurance coverage is not reasonable cause and no extension will be granted.

(5) Pay structure. A preferred worker's pay structure must be the same as the pay structure for other workers employed in similar jobs by the employer.

(6) Prevailing wage. Wages subject to reimbursement must be within the prevailing wage range for that occupation. The prevailing wage range is determined as follows:

(a) Examine the wages paid by the employer for other workers doing the same job;

(b) If no other workers are doing the same job, a labor market survey of the local labor market may be conducted; and

(c) If the labor market survey does not support the wage rate requested, the director will determine the wage subject to reimbursement.

(7) May not be combined with vocational training. Preferred Worker Program wage subsidies may not be combined with a wage reimbursement for a training plan under OAR 436-120, "Vocational Assistance to Injured Workers."

(8) Changes in employer. If the worker's employer changes during the wage subsidy agreement period due to a sale of the business, incorporation, or merger, the agreement can be transferred to the new employer by an addendum to the agreement approved by the director as long as the worker's job remains the same and the new employer is eligible under OAR 436-110-0310(1).

(9) Reimbursement requests.

(a) A completed and signed Form 2968, "Preferred Worker Program Wage Subsidy Reimbursement Request," must be submitted to the division with a legible copy of the worker's payroll records.

(b) Payroll records must include:

(A) The date of payment;

(B) The dates of work covered by the payment;

(C) The rate or rates of pay;

(D) Gross wages;

(E) The regular hourly rate or rates of pay, the number of regular hours worked, and pay for those hours;

(F) The number of overtime hours worked, if any, and pay for those hours; and

(G) The overtime rate or rates of pay.

(c) All requests for reimbursement must be made within one year of the wage subsidy agreement end date.

(10) May not be used for regular work. Wage subsidy may not be used if the worker has permanent restrictions but returns to regular work.

[ED. NOTE: Forms referenced available from the agency.]

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015 & 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025,436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 436-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300 & 436-110-0340; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0336
Wage Subsidy — Employer at Injury Activated

Wage subsidy may be activated by the employer at injury as follows:

(1) The job must be within the worker's injury-caused restrictions. If a worksite modification is necessary to meet this requirement, wage subsidy will be deferred until:

(a) The worksite modification is complete; or

(b) The employer accommodates the worker's injury-caused restrictions while waiting for the worksite modification to be complete.

(2) The employer must complete and sign Form 2190, "Preferred Worker Wage Subsidy Agreement," and submit it to the division in the time frames allowed in OAR 436-110-0290(1).

(3) The completed and signed job offer required in OAR 436-110-0290(2) must accompany the request for wage subsidy benefits, unless it was already submitted with another request.

(4) The employer at injury may use wage subsidy once during an eligibility period.

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 1-2010(Temp), f. & cert. ef. 4-15-10 thru 10-11-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0337
Wage Subsidy — Worker Activated

A wage subsidy may be requested by a worker as follows:

(1) The worker and employer must complete and sign Form 2190, "Preferred Worker Wage Subsidy Agreement," and submit it to the division within three years of the date of hire.

(2) A preferred worker may use wage subsidy as many times as needed, up to a maximum total reimbursement of $40,000. A worker with an exceptional disability may use wage subsidy twice with no maximum total reimbursement rate. The maximum total reimbursement will be restored if there is a subsequent claim closure, and the worker is unable to return to regular work.

(3) If the employer at injury uses wage subsidy for a job, the worker may not use wage subsidy for the same job.

(4) A worker can use a second wage subsidy with the same employer for a new job if:

(a) The majority of job duties have changed; and

(b) At least one year has passed from the end of the first wage subsidy period.

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0345
Employment Purchases — General Provisions

(1) General provisions. An employment purchase is assistance necessary for a worker to find, accept, or retain employment in Oregon. Purchases may be provided for a job with a nonsubject employer in Oregon, as long as that employer complies with the appropriate workers' compensation law. Employment purchases may not be used if the worker has permanent restrictions but returns to regular work. Except as provided in subsection (2)(i) of this rule, all purchases become the worker's property.

(2) Types of purchases. Employment purchases are limited to:

(a) Tuition, books, and fees for instruction provided by an educational entity accredited or licensed by an appropriate body in order to update existing skills or to meet the requirements of an obtained job. This category can be used as often as necessary up to a maximum of $2,000, with each use limited to $1,000;

(b) Temporary lodging, meals, and mileage to attend instruction when overnight travel is required. Reimbursable costs must be incurred within a 30-day period of time. The cost of meals, lodging, public transportation, and use of a personal vehicle will be reimbursed at the rate published in Bulletin 112. This category can be used as often as necessary up to a maximum of $1,000;

(c) Tools and equipment mandatory for employment. Purchases must not include items the worker possesses, duplicate worksite modification

items, vehicles, or items needed for worksite creation. This category can be used as often as necessary up to a maximum of $5,000, with each use limited to $2,500;

(d) Clothing required for the job. This category can be used as often as necessary up to a maximum of $1,000, with each use limited to $500;

(e) Transportation-related purchases, not including vehicles or vehicle maintenance, that enable the worker to commute to a job such as, but not limited to, bus fare, gasoline, or repairs to an existing vehicle. This category can be used as often as necessary up to a maximum of $1,000, requested within 90 days of hire;

(f) Moving expenses for a job if the new worksite is in Oregon and 50 or more miles from the worker's primary residence. When the worker's permanent disability from the injury precludes the worker from commuting the required distance, moving expenses may be provided to move within 50 miles of the worker's primary residence or within the distance the worker commuted for work at claim opening. The worker must complete, sign, and submit Form 3293, "Preferred Worker Moving Assistance Agreement." Moving expenses are limited to one use. Expenditure is limited to:

(A) The cost of moving household goods weighing not more than 10,000 pounds and reasonable costs of meals and lodging for the worker. The cost of meals, lodging, public transportation, and use of a personal vehicle will be paid at the rate published in Bulletin 112. Lodging and meals are limited to a maximum period of two weeks. Mileage for one personal vehicle is limited to a single one-way trip; and

(B) Rental allowance for the worker's primary residence limited to first month's rent as specified in the rental agreement, nonrefundable deposit in an amount not to exceed the first month's rent, and a required credit check for that residence;

(g) Initiation fees, or back dues and one month's current dues, required by a labor union. This category can be used as often as necessary up to a maximum of $1,000;

(h) Occupational certification, licenses, and related testing costs, drug screen testing, physical examinations, or membership fees required for the job. This category can be used as often as necessary up to a maximum of $1,000, with each use limited to $500;

(i) Worksite creation costs that are limited to equipment, furnishings, or other things the employer needs to create a new job for the worker. A completed and signed Form 4122, "Preferred Worker Worksite Creation Agreement," must be submitted to the division. All items purchased are the property of the employer. This category can be used as often as necessary up to a maximum of $10,000, with each use limited to $5,000; and

(j) Miscellaneous purchases that do not fit into subsections (a) through (i) of this section, subject to approval by the director. This category does not include a vehicle purchase. This category can be used as often as necessary up to a maximum of $2,500.

(3) Payment and reimbursement.

(a) Costs of employment purchases will be paid by reimbursement or by other instrument of payment approved by the director.

(b) The director will provide payment but will not otherwise assume responsibility for employment purchases.

(c) The person or entity that purchased the items may request reimbursement by submitting to the division a legible copy of an invoice or receipt showing payment has been made for the items purchased. Reimbursement will be made for only those items and costs approved and paid.

(d) All requests for reimbursement must be made within one year of the end date on Form 2350, "Preferred Worker Employment Purchase Agreement."

(e) Reimbursed costs may not be charged by the insurer to the employer as claim costs or by any other means.

(4) Placement services.

(a) Placement assistance services provided to a preferred worker by a certified vocational counselor or any public or private agency that provides placement services are reimbursable as provided in this section.

(A) Placement assistance services provide the worker with skills to find employment, including, but not limited to, intake, resume writing, interview skills, resource development, online application development, job search skills, job coaching, and employer contacts.

(B) The counselor or agency representative and the worker must complete, sign, and submit to the division Form 4875, "Preferred Worker Placement Assistance Agreement," with an estimate of services to be provided.

(C) Placement assistance is limited to a maximum expenditure of $1,000 for services described in paragraph (A). Payment for these services is based on a billable hourly rate of $85 (or at one-half rate for travel) and may be made to the counselor or agency that provided placement services to enable the worker to find employment, regardless of whether the worker finds employment.

(D) Only one placement assistance agreement may be in approved status at any given time.

(E) Placement assistance may not be combined with vocational assistance under OAR 436-120.

(F) If the worker finds employment as a result of the placement services, an employment placement payment of $500 may be paid to the counselor. If the worker remains employed in that position for at least 30 days, an additional incentive payment of $500 may be paid to the counselor or agency that provided the placement services.

(G) Employment placement payment and subsequent incentive payment is limited to a maximum of three employment placements.

(H) Placement and incentive payments are limited to one use each per employer.

(b) To request payment for placement services provided, a completed and signed Form 5135, "Preferred Worker Program Placement Payment Request," must be submitted to the division along with a detailed invoice of services provided.

(c) All requests for reimbursement for placement services must be made within one year of the placement assistance agreement end date.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015 & 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025,436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 436-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300 & 436-110-0340; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0346

Employment Purchases – Employer at Injury Activated

Conditions for use of employment purchases by the employer at injury are:

(1) The employer must submit to the division a completed Form 2350, "Preferred Worker Employment Purchase Agreement," listing items that are required of the worker to perform the job for which the worker is employed; and

(2) The employer may use each employment purchase category once per eligibility period.

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0347

Employment Purchases — Worker Activated

(1) Conditions for use of employment purchases by a worker are:

(a) Except for moving expenses, placement assistance, and miscellaneous purchases needed to find a job, the worker and employer must submit a completed employment purchase agreement listing items that are required of the worker to obtain or perform the job;

(b) Employment purchases may be used with a nonsubject employer in Oregon; and

(c) The limits for each type of purchase will be restored if there is a subsequent claim closure and the worker is unable to return to regular work.

(2) A preferred worker may request employment purchases as follows:

(a) The worker must contact the division directly for assistance in receiving employment purchases. The worker may make the request before employment, as long as there is a job offer with a start date, but not more than three years after the date of hire; and

(b) Form 2350, "Preferred Worker Employment Purchase Agreement," must be completed and signed by the worker and employer and submitted to the division. Only the worker's signature is required if the request is for moving expenses, placement assistance, or the miscellaneous category.

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0350
Worksite Modification — General Provisions

(1) Worksite modification defined.

(a) Worksite modification means altering a worksite by purchasing, modifying, or supplementing equipment, or changing the work process, to enable a worker to work within the restrictions caused by a compensable injury or occupational disease.

(b) For purposes of the Preferred Worker Program, "worksite" means a primary work area that is in Oregon, already constructed, and available for a worker to use to perform the required job duties. The worksite may be the employer's, client's, or worker's premises, property, or equipment used to conduct business under the employer's or client's direction and control. A worksite may include a worker's personal property or vehicle if required to perform the job. If the worksite is mobile, it must be available in Oregon for inspection and modification.

(2) Conditions for use. Conditions for the use of worksite modification assistance are as follows:

(a) Modifications must allow the worker to perform the job duties within the worker's injury-caused permanent restrictions. In order to determine appropriate worksite modifications, the division worksite modification consultants have discretion to use reports by a medical service provider specific to the worker, specific documented "best practices" described by a medical service provider or authority, and their own professional judgment and experience;

(b) A job analysis that includes the duties and physical demands of the job before and after modification may be required to show how the modification will overcome the worker's restrictions. The job analysis may be submitted to the attending physician for approval before the modification is performed;

(c) Except as provided in OAR 436-110-0351(2) for employer at injury activated modifications, modifications can be used up to a maximum of $50,000 per eligibility period, with each use limited to $35,000. If the worker has an exceptional disability, a modification more than $35,000 may be provided;

(d) Modifications not to exceed $2,500 may be provided that would reasonably be expected to prevent further injury or exacerbation of the compensable injury or occupational disease, including any disability resulting from the compensable injury or occupational disease. A division worksite modification consultant will determine the appropriateness of this type of modification based upon his or her professional judgment and experience, reports by a medical service provider specific to the worker, or specific documented "best practices" described by a medical service provider or authority. Costs of the modifications are included in the calculation of the total worksite modification costs;

(e) Modifications are limited to $2,500 for on-the-job training under OAR 436-120, "Vocational Assistance to Injured Workers," or other similar on-the-job training program when the trainer is not the employer at injury. A modification will not be approved for any other type of training;

(f) Modifications up to $2,500 may be provided to protect the items approved in the worksite modification agreement from theft or damage from the weather. Insurance policy premiums will not be paid;

(g) When a vehicle is being modified, the vehicle owner must provide proof of ownership and insurance coverage. The worker must have a valid driver license with any applicable classification or endorsement;

(h) Rented or leased vehicles and other equipment will not be modified;

(i) Modifications must be reasonable, practical, and feasible, as determined by the director;

(j) When the director determines the appropriate form of modification and the worker or employer requests a form of modification equally appropriate but with a greater cost, upon director approval, funds equal to the cost of the form of modification identified by the director may be applied toward the cost of the modification desired by the worker or employer;

(k) A modification may include rental of tools, equipment, fixtures, or furnishings to determine the feasibility of a modification. It may also include consultative services necessary to determine the feasibility of a modification, or to recommend or design a worksite modification;

(l) Rental of worksite modification items and consultative services require director approval and are limited to a cost of up to $5,000 each. The cost for rental of worksite modification items and consultative services does not apply toward the total cost of a worksite modification;

(m) Modification equipment will become the property of the employer, worker, or client on the end date of the worksite modification agreement, or when the worker's employment ends, whichever occurs first. The director will determine ownership of worksite modification equipment before approving an agreement and has the final authority to assign property;

(n) The director may request a physical capacities evaluation, work tolerance screening, or review of a job analysis to quantify the worker's injury-caused permanent restrictions. The cost of temporary lodging, meals, public transportation, and use of a personal vehicle necessary for a worker to participate in one or more of these required activities will be reimbursed at the rate published in Bulletin 112. The cost of the services described in this subsection must be paid by the insurer;

(o) If the property provided for the modification is damaged, in need of repair, or lost, the director will not repair or replace the property;

(p) The employer must not dispose of the property provided for the modification or reassign it to another worker while the worker is employed in work for which the modification is necessary or before the end of the agreement without director and worker approval. Failure to repair or replace the property, or inappropriate disposal or reassignment of the property, may result in sanctions under OAR 436-110-0900; and

(q) The worker must not dispose of the property provided for the modification while employed in work for which the modification is necessary or before the end of the agreement without director approval. Failure to repair or replace the property, or inappropriate disposal of the property, may result in sanctions under OAR 436-110-0900.

(3) Requests for assistance, payment, and reimbursement.

(a) A worker, employer, or the worker's or employer's representative, may request worksite modification assistance.

(b) A division worksite modification consultant will determine if competitive quotes are required.

(c) The director must create and approve a completed and signed worksite modification agreement before any reimbursement or payment.

(d) Costs of approved worksite modifications will be paid by reimbursement or other instrument of payment approved by the director.

(e) The director will provide payment but will not otherwise assume responsibility for worksite modifications.

(f) The person or entity that purchased the items may request reimbursement by submitting to the division proof of payment for the items purchased. Reimbursement will be made for only those items and costs approved and paid.

(g) All requests for reimbursement must be made within one year of the date the worksite modification agreement ends. No specific form is required.

(h) Reimbursed costs may not be charged by the insurer to the employer as claims costs or by any other means.

[Publications: Publications referenced are available from the agency]
Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015 & 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 436-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300 & 436-110-0340; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 1-2015, f. 1-29-15, cert. ef. 3-1-15; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0351
Worksite Modification — Employer at Injury Activated

Conditions for use of worksite modifications by the employer at injury are as follows:

(1) The employer at injury may use worksite modification assistance once for a job provided for its injured worker, or a second time if the worker changes to another job with the employer at injury within the timeframes allowed in OAR 436-110-0290(1);

(2) Modifications are limited to a maximum of $35,000 on the claim that qualified the worker for assistance. A modification of more than $35,000 may be provided if the worker has an exceptional disability; and

(3) Modifications may be provided for requests received within 180 days from the worker's claim closure date. Additional modifications may be provided under an approved agreement by addendum for requests received within three years from the date the worker started work for the

employer in employment for which the worksite modification request was made.

Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 1-2010(Temp), f. & cert. ef. 4-15-10 thru 10-11-10; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0352
Worksite Modification — Worker Activated

Conditions for use of worksite modification assistance by the worker are as follows:

(1) Modifications may be provided for requests received within three years from the date of hire;

(2) A worker may use worksite modification assistance as often as necessary but only once per employer, with each use is limited to $35,000; and

(3) A worker can use a second worksite modification with the same employer for a new job if the majority of the job duties have changed.

Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 4-2010, f. 9-15-10, cert. ef. 10-12-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0850
Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the director. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the director directly or from future reimbursements by offset. If the director finds upon audit that procedures that led to disallowed reimbursements are still being used, the director may withhold further reimbursements until corrections satisfactory to the director are made.

(2) An insurer or employer must maintain claim records, notices, worker payroll records, reports, receipts, and documentation of payment supporting re-employment assistance costs for which reimbursement has been requested or payment has been made. These records must be maintained for a period of three years after the last reimbursement request or payment.

(3) The director reserves the right to visit the worksite to determine compliance with the agreement under which re-employment assistance has been provided.

Stat. Auth.: ORS 656.455, 656.622, 656.726(4) & 731.475
Stats. Implemented: ORS 656.455, 656.622 & 731.475
Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0100; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0450; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-110-0900
Sanctions

(1) Penalties for false statement or report or misrepresentation. Any person who knowingly makes any false statement or representation to the director or an employee of the director for the purpose of obtaining any benefit or payment from the Preferred Worker Program, or who knowingly misrepresents the amount of a payroll or knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for sanction. Reasons for the director to sanction an individual certified under OAR 436-120, a vocational assistance provider authorized under OAR 436-120, an agency of the State of Oregon, an insurer, an employer, or a preferred worker include, but are not limited to, the following:

(a) Misrepresenting information in order to obtain re-employment assistance. Examples of misrepresentation include:

(A) Changing a job description or job title in order to obtain benefits when there are not corresponding job duty changes; and

(B) Obtaining a worker's signature on an incomplete, incorrect, or blank agreement or reimbursement request;

(b) Making a serious error or omission that resulted in the director approving a Preferred Worker Program agreement issuing a preferred worker card, or reimbursing claim costs in error;

(c) Failing to abide by the terms and conditions of a Preferred Worker Program agreement;

(d) Failing to abide by the provisions of these rules or ORS 656.990;

(e) Failing to return required receipts or invoices;

(f) Submitting false reimbursement requests or job analyses; or

(g) Altering a payment or form, or purchasing unauthorized items.

(3) Possible sanctions. The director may order one or more of the following sanctions:

(a) Ordering the person being sanctioned to repay the department for re-employment assistance costs incurred, including the department's legal costs;

(b) Prohibiting the person being sanctioned from negotiating or arranging re-employment assistance for such period of time as the director deems appropriate;

(c) Decertifying an individual or vocational assistance provider under the authority of OAR 436-120;

(d) Ordering an employer or worker ineligible for re-employment assistance for a specific period of time; or

(e) Pursuing civil or criminal action against the party.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622 & 656.990
Hist.: WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0110; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0500; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0003
General Provisions

(1) Purpose of these rules. The purpose of the rules in OAR 436-120 is to:

(a) Prescribe uniform standards for determining eligibility, delivery, and payment for vocational services to injured workers;

(b) Prescribe procedures for resolving disputes; and

(c) Establish standards for the certification of counselors and providers.

(2) Applicability of rules.

(a) These rules govern vocational assistance under the workers' compensation law on or after the effective date of these rules except as OAR 436-120 otherwise provides.

(b) The director's decisions under OAR 436-120-0008 regarding eligibility will be based on the rules in effect on the date the insurer issued the notice. The director's decisions regarding the nature and extent of assistance will be based on the rules in effect at the time the assistance was provided. If the director orders future assistance, such assistance must be provided in accordance with the rules in effect at the time assistance is provided.

(c) Under these rules a claim for aggravation or reopening a claim to process a newly accepted condition is considered a new claim for purposes of vocational assistance eligibility and vocational assistance, except as otherwise provided in these rules.

(3) Director's discretion.

(a) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(b) If the worker has returned to work with the employer at injury, the director reserves the right to verify whether the employment is suitable.

(4) Submitting documents or information, calculating time.

(a) Documents or information required under these rules to be submitted to the division may be submitted in any of the following ways:

(A) Mailed to the division's mailing address with sufficient postage and placed in the custody of the U.S. Postal Service;

(B) Physical delivery to the division's Salem office;

(C) Faxed, if the document transmitted indicates it has been delivered by fax, is sent to the correct fax number, and indicates the date it was sent; or

(D) Any other method authorized by the director.

(b) Timeliness of any document required by these rules to be submitted to the division is determined as follows:

(A) If a document is mailed, it will be considered submitted on the date it is postmarked.

(B) If a document is faxed, it must be received by 11:59 p.m. Pacific Time to be considered submitted on that date.

(C) If a document is delivered, it must be delivered during regular business hours and marked as received to be considered submitted on that date.

(c) Time periods allowed under these rules are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(5) Availability of forms. The forms and bulletins referenced in these rules are available on the division's website at wcd.oregon.gov.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stats. Implemented: ORS 656.206, 656.340
Hist.: WCB 1-1976, f. 3-29-76, ef. 4-1-76; WCD 3-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 1-1978(Admin), f. & ef. 2-1-78; WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0004, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0005
Definitions

For the purpose of these rules, unless the context requires otherwise:

(1) "Cost-of-living matrix" is a chart issued annually by the division in Bulletin 124 that publishes the conversion factors, effective July 1 of each year, used to adjust for changes in the cost-of-living rate from the date of injury to the date of calculation. The conversion factor is based on the annual percentage increase or decrease in the average weekly wage, as defined in ORS 656.211.

(2) "Counselor" means the vocational assistance counselor certified under these rules to provide vocational assistance to injured workers and activities for determining a worker's eligibility for vocational assistance.

(3) "Director" means the director of the Department of Consumer and Business Services, or the director's delegate for the matter.

(4) "Division" refers to the Workers' Compensation Division of the Department of Consumer and Business Services.

(5) "Employer at injury" means the organization that employed the worker when the worker sustained the injury or occupational disease.

(6) "Insurer" means the insurance company or self-insured employer responsible for the workers' compensation claim.

(7) "Provider" means the vocational assistance provider that is an insurer or other public or private organization registered under these rules to provide vocational assistance to injured workers and activities for determining a worker's eligibility for vocational assistance.

(8) "Reasonable cause" may include, but is not limited to, a medically documented limitation in a worker's activities due to illness or medical condition of the worker or the worker's family, financial hardship, incarceration for less than six months, or circumstances beyond the reasonable control of the worker. "Reasonable cause" for failure to provide information or participate in activities related to vocational assistance will be determined based upon individual circumstances of the case.

(9) "Reasonable labor market" for an occupation means it can be said to have reasonable employment opportunities if competitively qualified workers can expect to find equivalent jobs in the occupation within a reasonable period of time. A reasonable period of time, for workers in the majority of occupations, would be the six months that they could collect regular unemployment insurance benefits, if they were entitled to them.

(10) "Regular employment" means the employment the worker held at the time of the injury or at the time of the claim for aggravation, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of aggravation, the employment the worker held on the last day of work before the aggravation claim. If the basis for potential eligibility is a reopening to process a newly accepted condition, "regular employment" is the employment the worker held at the time of the injury. When the condition arose after claim closure, "regular employment" is determined as if it were an aggravation claim.

(11) "Substantial handicap to employment" means the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills, and abilities to be employed in suitable employment.

(a) "Knowledge" means an organized body of factual or procedural information derived from the worker's education, training, and experience.

(b) "Skills" means the demonstrated mental and physical proficiency to apply knowledge.

(c) "Abilities" means the cognitive, psychological, and physical capability to apply the worker's knowledge and skills.

(12)(a) "Suitable employment" or "suitable job" means employment or a job:

(A) For which the worker has the necessary physical capacities, knowledge, skills, and abilities;

(B) Located where the worker customarily worked, or within reasonable commuting distance of the worker's residence. A reasonable commuting distance is no more than 50 miles one-way modified by other factors including, but not limited to:

(i) Wage of the job;

(ii) The pre-injury commute;

(iii) The worker's physical capacities, if they restrict the worker's ability to sit or drive for 50 miles;

(iv) Commuting practices of other workers who live in the same geographic area; and

(v) The distance from the worker's residence to the nearest cities or towns that offer employment opportunities;

(C) That pays a suitable wage or would average on a year-round basis a suitable wage;

(D) That is permanent. Temporary work is suitable if the worker's job at injury was temporary and the worker has transferable skills to earn, on a year-round basis, a suitable wage; and

(E) For which a reasonable labor market as described under OAR 436-120-0157 is documented to exist.

(b) "Suitable employment" or "suitable job" may also be modified or new employment resulting from an employer at injury activated use of the Preferred Worker Program under OAR 436-110, as described in OAR 436-120-0165(1)(c).

(13) "Suitable wage" means:

(a) For the purpose of determining eligibility for vocational assistance, a wage at least 80 percent of the adjusted weekly wage.

(b) For the purpose of providing or ending vocational assistance, a wage as close as possible to 100 percent of the adjusted weekly wage. This wage may be considered suitable if less than 80 percent of the adjusted weekly wage, if the wage is as close as possible to the adjusted weekly wage.

(14) "Training" means a vocational rehabilitation service provided to a worker who is enrolled and actively engaged in an approved training plan as documented on Form 1081, "Training Plan."

(15) "Transferable skills" means the knowledge and skills demonstrated in past training or employment that make a worker employable in suitable new employment. More general characteristics such as aptitudes or interests do not, by themselves, constitute transferable skills.

(16) "Vocational assistance" means any of the services, goods, allowances, and temporary disability compensation under these rules to assist an eligible worker return to work. This does not include activities for determining a worker's eligibility for vocational assistance.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCB 7-1966, f. & ef. 6-30-66;WCB 6-1973, f. 12-20-73, ef. 1-11-74; WCB 45-1974(Temp), f. & ef. 11-5-74; WCD 4-1975(Admin), f. 2-6-75, ef. 2-25-75; WCB 1-1976, f. 3-29-76, ef. 4-1-76; WCD 3-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 1-1978(Admin), f. & ef. 2-1-78; WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0005, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 23-1996, f. 12-13-96, cert. ef. 2-1-97; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 1-2015, f. 1-29-15, cert. ef. 3-1-15; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0008
Administrative Review and Hearings

(1) Administrative review.

(a) A worker wanting review of any vocational eligibility evaluation or vocational assistance matter must request administrative review by the director.

(b) Under ORS 656.340(11) and OAR 436-120-0185 when the worker and insurer are unable to agree on a counselor, the insurer must request administrative review by the director.

(c) Effective vocational assistance is best realized in a nonadversarial environment. The first objective of administrative review is to bring the parties to resolution through alternative dispute resolution procedures, including mediation conferences, whenever possible and appropriate. When a dispute is not resolved through mutual agreement or dismissal, the director will close the record and issue a director's review and order.

(d) The worker's request for review must be submitted to the division no later than the 60th day after the date the worker received written notice of the insurer's action.

(e) Issues raised by the worker where written notice was not provided may be reviewed at the director's discretion.

(f) The worker, insurer, employer at injury, and provider must supply needed information, attend conferences and meetings, and participate in the administrative review process as required by the director.

(A) Upon the director's request, any party to the dispute must provide available information within 14 days of the request.

(B) The insurer must promptly schedule, pay for, and submit to the division any medical or vocational tests, consultations, or reports required by the director.

(C) The worker, insurer, employer at injury, or provider must simultaneously provide copies of material to the other parties to the dispute when submitting material to the division.

(D) Failure to comply with this subsection may result in the director dismissing the administrative review or deciding the issue on the basis of available information when the worker, insurer, provider, or employer at injury fails to comply without reasonable cause.

(g) The director may issue a letter of agreement when the parties resolve a dispute within the scope of these rules.

(A) Any agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(B) The agreement will become effective on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise.

(C) The director may revise a letter of agreement.

(h) The parties have 60 days from the date the director's review and order is issued to request a hearing under OAR 436-001-0019.

(i) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law.

(j) A party may request reconsideration of a director's review and order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence that could not reasonably have been discovered and produced during the review.

(A) The director may grant or deny a request for reconsideration at the director's sole discretion.

(B) A request for reconsideration must be received by the division before the director's review and order becomes final or, if appealed, before the proposed and final order is issued.

(C) The parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(D) Parties must simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(E) A request for reconsideration does not stay the 60-day time period within which the parties may request a hearing.

(2) Attorney fees. Attorney fees will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 to 436-001-0440.

(3) Hearings before an administrative law judge.

(a) Under ORS 656.340(16) and 656.704(2), any party that disagrees with an order issued under subsection (1)(c) of this rule or a dismissal may request a hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(b) Under ORS 656.704(2), any party that disagrees with an order of dismissal based on lack of jurisdiction or denial of reimbursement for vocational assistance costs may request a hearing as provided in OAR 436-001-0019 within 30 days after the party received the dismissal or written denial.

(c) Under ORS 656.704(2), an insurer sanctioned under OAR 436-120-0900, a provider or counselor sanctioned under ORS 656.340(9) and OAR 436-120-0915, a provider denied registration under ORS 656.340(9)(a) and OAR 436-120-0800, or an individual denied certification under ORS 656.340(9)(a) and OAR 436-120-0810, may request a hearing as provided in OAR 436-001-0019 no later than 60 days after the party received notification of the action.

(4) Contested case hearings of civil penalties. Under ORS 656.740 an insurer or an employer may appeal a proposed order or proposed assessment of civil penalty issued under ORS 656.745 and OAR 436-120-0900 as follows:

(a) The insurer or employer must submit the request for hearing in writing to the division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The party must submit the request to the division within 60 days after the mailing date of the notice of the proposed order or assessment.

(c) The division will forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(d) The Hearings Division will conduct the hearing under ORS 656.740 and ORS chapter 183.

(5) Director's order. At any time, the director may order the insurer to determine eligibility or provide specified vocational assistance to achieve compliance with ORS chapter 656 and these rules. The order may be appealed as provided by statute and these rules.

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

Stat. Auth.: ORS 656.704(2) & 656.726(4)

Stats. Implemented: ORS 656.704, 656.340, 656.447, 656.740, 656.745

Hist.: WCD 9-1982(Admin), f. 5-28-82, ef. 6-1-82; WCD 2-1983(Admin), f. & ef. 6-30-83; Renumbered from 436-061-0970, 5-1-85; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0191, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0210 & 436-120-0260; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 23-1996, f. 12-13-96, cert. ef. 2-1-97; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0012

General Requirements For Notices and Warnings

(1) Insurer or provider may issue. The insurer is responsible for mailing all notices and warnings required by these rules but may delegate that responsibility to the provider that is providing vocational assistance to the worker.

(2) Required content. All notices and warnings to the worker issued under these rules must:

(a) Use the applicable heading. If a notice is used for more than one purpose, it must include all the headings that apply;

(b) Be in writing, signed, and dated;

(c) State the basis for the decision;

(d) Include the effective date of each action in the heading;

(e) Cite the relevant rules;

(f) Include the worker's appeal rights. All notices and warnings except those notifying a worker of entitlement to training or deferral of vocational assistance eligibility must contain the worker's appeal rights in bold type, as follows:

"If you disagree with this decision, you should contact [insert the person's name and the insurer name] within five days of receiving this letter to discuss your concerns. If you are still dissatisfied, you must contact the Workers' Compensation Division within 60 days of receiving this letter or you will lose your right to appeal this decision. A consultant with the division can talk with you about the disagreement and, if necessary, will review your appeal. The address and telephone number of the division are: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 503-947-7816 or 1-800-452-0288."; and

(g) Include the telephone number of the Ombudsman for Injured Workers: 1-800-927-1271.

(3) Mailing and copies. All notices and warnings must:

(a) Be mailed to the worker's last known address by both regular and certified mail; and

(b) Be copied to the division and worker's attorney, if any, at the same time the notice or warning is mailed to the worker.

(4) Effective date. A notice is not effective until it is sent to all required parties including the worker's attorney.

(5) Requirements for warning letters.

(a) A warning letter can be issued at any time during the vocational eligibility evaluation or vocational assistance process.

(b) Warning letters do not require specific language in the headings but must include a heading clearly indicating the purpose of the warning.

(c) A warning letter must state what the worker must do, and by when, to avoid ineligibility or the ending of eligibility or training.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stats. Implemented: ORS 656.340

Hist.: WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0600, 436-120-0610 & 436-120-0620 [WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; Renumbered from 436-120-0004, WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0115

Vocational Eligibility Evaluation

(1) Purpose of eligibility evaluation. An eligibility evaluation is done to determine whether the worker is or is not eligible for vocational assistance.

(2) When an eligibility evaluation is not required. An eligibility evaluation is not required if:

(a) The worker's claim is reopened under Own Motion under ORS 656.278;

(b) The worker is receiving permanent total disability benefits; or

(c) The worker is deceased.

(3) When an eligibility evaluation is required. Except as provided in OAR 436-120-0117, the insurer is required to begin an eligibility evaluation for workers with accepted disabling claims within five days of any of the following conditions:

(a) The insurer receives information such as medical or investigative reports that indicate, before the worker is medically stationary, the worker is likely eligible for vocational assistance;

(b) The worker is medically stationary, is not currently receiving vocational assistance, and:

(A) Has not returned to or been released to regular employment; or

(B) Has not returned to other suitable employment with the employer at the time of injury or aggravation; or

(c) Eligibility was previously determined under the current opening of the claim and the insurer has accepted a new condition.

(4) Services may be provided at any time. Nothing in these rules prevents an insurer from finding a worker eligible and providing vocational assistance at any time.

(5) Worker request for vocational assistance. If the insurer receives a request for vocational assistance from the worker and the insurer is not required to do an eligibility evaluation, the insurer may not deny eligibility for assistance, but must notify the worker in writing within 14 days of the request of:

(a) The reasons an eligibility evaluation is not required;

(b) The circumstances that require an eligibility evaluation; and

(c) Instructions to contact the division with questions about vocational assistance eligibility requirements and procedures.

(6) The eligibility evaluation process.

(a) The eligibility evaluation must be done by a counselor.

(b) At the insurer's request, the worker must provide vocationally relevant information needed to determine eligibility within a reasonable time set by the insurer.

(c) The insurer must provide the counselor with all relevant vocational and medical information.

(d) The eligibility evaluation process, including notifying the worker of the results under section (9) of this rule, must be completed within 30 days of when the process began under section (3) of this rule, unless extended under section (7) of this rule.

(e) Either the insurer or the counselor may notify the worker of the results of the eligibility evaluation under section (9) of this rule.

(7) Extension of time.

(a) The counselor may extend the time frame in section (6) of this rule for completing the eligibility evaluation if the counselor is unable to obtain needed information from the worker, employer, or medical provider.

(b) An extension of time may be for no more than 30 days.

(c) The counselor must notify the worker of the extension under section (8) of this rule, and submit a copy of the letter to the division.

(8) Notice of extension of time. The letter informing the worker that the time frame for completing the eligibility evaluation process has been extended must:

(a) Clearly indicate the purpose of the letter;

(b) Explain the reason for the extension of time;

(c) Explain what information is necessary to complete the eligibility evaluation process;

(d) State when the eligibility evaluation process is expected to be completed;

(e) Be mailed to the worker within five days of the date the counselor determines an extension is needed under subsection (7)(a) of this rule; and

(f) Include the following language in bold type:

"If you have questions about the vocational assistance process, contact [use appropriate reference to the insurer]. If you still have questions contact the Workers' Compensation Division's toll free number 1-800-452-0288."

(9) Results of the eligibility evaluation. The results of the eligibility evaluation must be mailed to the worker following the requirements for the appropriate notice under subsection (a) or (b) of this section.

(a) The NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE must:

(A) Include the worker's responsibilities, as specified in OAR 436-120-0197(2) and 436-120-0520(1);

(B) Include the following statement in bold type:

"You have the right to request a return-to-work plan conference if the insurer does not approve a return-to-work plan within 90 days of determining you are entitled to a training plan, or within 45 days of determining you are entitled to a direct employment plan. The purpose of the conference will be to identify and remove all obstacles to return-to-work plan completion and approval. The insurer, the worker, the counselor, and any other parties involved in the return-to-work process must attend the conference. The insurer or the worker may request a conference with the division if other delays in the vocational assistance process occur. Your request for this conference should be directed to the Employment Services Team of the Workers' Compensation Division. The address and telephone number of the division are: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 503-947-7816 or 1-800-452-0288.";

(C) Explain that the worker and the insurer must agree on the selection of a counselor, and:

(i) Provide instructions for the worker to access the list of providers on the division's website (wcd.oregon.gov/rtw/Pages/voc-assistance.aspx);

(ii) Include a phone number for the worker to call to request a paper copy of the list; and

(iii) Include the following language in bold type:

"If you have questions about the vocational counselor selection process, contact [use appropriate reference to the insurer]. If you still have questions, call the Workers' Compensation Division at 1-800-452-0288.";

(D) Include information about the Preferred Worker Program;

(E) Explain what the worker can do if he or she disagrees with something the insurer does; and

(F) Explain direct employment services and state the worker is not entitled to training, if the worker is entitled to direct employment services but not training.

(b) The NOTICE OF INELIGIBILITY FOR VOCATIONAL ASSISTANCE must include:

(A) Information about services that may be available at no cost from the Oregon Employment Department or the Office of Vocational Rehabilitation Services;

(B) A brief description of the Preferred Worker Program benefits and contact information. The information can be part of the notice or a separate document attached to the notice; and

(C) A list of suitable occupations the worker can perform without being retrained, if the notice is based on a finding that the worker does not have a substantial handicap to employment.

(10) Multiple claims. Vocational assistance may only be provided for one claim at a time. If the worker is eligible for vocational assistance under two or more claims, the claim for the injury with the most severe vocational impact is the claim that gave rise to the need for vocational assistance. The parties may agree to provide services for more than one claim at a time, and extend time and fee limits beyond those allowable in these rules.

Stat. Auth.: ORS 656.340, 656.726(4)

Stats. Implemented.: ORS 656.340

Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0111, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0060; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0035; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0330 & 436-120-0370; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; Renumbered from 436-120-0320 by WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0117

Deferral of Eligibility Evaluation

(1) Deferral of eligibility evaluation. The eligibility evaluation may be deferred when all of the following circumstances exist:

(a) The employer at injury has activated Preferred Worker Program benefits under OAR 436-110;

(b) The employer has made a written job offer to the worker that includes the following information:

(A) The start date;

(B) Wage and hours;

(C) Job site location;

(D) Description of job duties that includes physical requirements; and

(E) A statement that the job does not begin until any modifications are in place;

(c) The worker has agreed in writing to accept the new or modified job; and

(d) If the new or modified job needs worksite modifications to enable the worker to perform the job duties within the worker's injury-caused limitations:

(A) The modifications are in progress but not yet complete and the worker is working in a temporary modified position with the employer at injury that accommodates the worker's restrictions; or

(B) The worksite modifications are in place and the worker is working in and receiving payment for the new or modified job.

(2) Notice of deferral.

(a) When the eligibility evaluation process is deferred under this rule, the insurer must mail the worker a NOTICE OF DEFERRAL OF VOCATIONAL ASSISTANCE ELIGIBILITY EVALUATION.

(b) The notice must be mailed within five days of the date the conditions in section (1) exist.

(c) The notice must:

(A) Inform the worker that the eligibility evaluation has been deferred because the employer at injury has activated preferred worker benefits;

(B) Inform the worker that, if the job with the employer at injury does not begin on the date stated in the job offer letter, the worker can ask the insurer to resume the eligibility evaluation process; and

(C) Include the following language in bold type:

"If you have questions about the deferral of the process for determining your eligibility for vocational assistance, contact [use appropriate reference to the insurer]. If you still have questions contact the Workers' Compensation Division's toll free number 1-800-452-0288."

(3) Resumption of eligibility evaluation process. If the eligibility evaluation has been deferred under this rule, the insurer must resume the process within 14 days of:

(a) A determination that preferred worker benefits will not be provided;

(b) Termination of the Preferred Worker Program agreement;

(c) Termination of the job offer; or

(d) The temporary modified position ends and the worksite modifications are still in progress.

Stat. Auth.: ORS 656.340, 656.726(4)

Stats. Implemented: ORS 656.340

Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0111, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0060; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0035; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0330 & 436-120-0370; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; Renumbered from 436-120-0320 by WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; Renumbered from 436-120-0155, WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0145
Vocational Assistance Eligibility

(1) A worker whose permanent total disability benefits have been terminated by a final order is eligible for vocational assistance.

(2) A worker is eligible for vocational assistance if all of the following conditions are met:

(a) The worker is authorized to work in the United States;

(b) The worker is available in Oregon or within commuting distance of Oregon, unless:

(A) The worker states in writing that within 30 days of being determined eligible for vocational assistance the worker will move back to Oregon, or within commuting distance of Oregon, at the worker's expense;

(B) The worker did not work and live in Oregon at the time of the injury;

(C) The worker needs to live outside of Oregon due to financial hardship, family circumstances over which the worker has no control, or other similar situation; or

(D) The training program or supporting labor market for a specific vocational goal is only available outside of Oregon;

(c) As a result of the limitations caused by the injury or aggravation, the worker:

(A) Is not able to return to regular employment;

(B) Is not able to return to suitable and available work with the employer at injury or aggravation; and

(C) Has a substantial handicap to employment and requires assistance to overcome that handicap;

(d) The worker was not employed in suitable employment for at least 60 days after the injury or aggravation;

(e) The worker did not refuse or fail to make a reasonable effort in available light-duty work intended to result in suitable employment. Before finding the worker ineligible, the insurer must document the existence of one or more suitable jobs that would be available for the worker after completion of the light-duty work. If the employer at injury offers such employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(f) The worker is available for vocational assistance. If the worker is not available, the insurer must determine if the reasons are for reasonable or unreasonable cause before finding the worker ineligible. If the reason was for incarceration, this reason must be stated in the notice to the worker. Declining vocational assistance to accept modified or new employment that results from an employer at injury activated use of the Preferred Worker Program, under OAR 436-110, is reasonable cause; and

(g) The worker did not refuse or otherwise relinquish his or her rights to vocational assistance in writing.

(3) Individuals covered under ORS 656.033, 656.046, 656.135, or 656.138 (work experience program participants, apprentices, trainees), are eligible for vocational assistance if they otherwise meet the eligibility requirements in section (2) of this rule. For purposes of vocational assistance:

(a) The employer at injury is the district, college, or school conducting the program or project in which the individual was injured;

(b) Regular employment is the job for which the individual was being trained at the time of the injury; and

(c) The assumed wage upon which premium was based, but in no event less than minimum wage, should be used to determine suitable wage under OAR 436-120-0147.

(4) The worker must participate in the vocational assistance process and must provide relevant information. If the worker does not participate, or fails to provide relevant information, the insurer must issue a written warning before finding the worker ineligible under this rule.

(5) The worker must not misrepresent a matter material to evaluating eligibility.

Stat. Auth.: ORS 656.340, 656.726(4)

Stats. Implemented: ORS 656.206, 656.340

Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0126, 5-1-85; WCD 7-1985, 12-12-85, eff. 1/1/86; Renumbered from 436-120-0090, WCD 11-1987, 12-17-87, eff. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0045; Renumbered from 436-061-0111, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0060; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0035; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0330 & 436-120-0370; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; Renumbered from 436-120-0320 & 436-120-0350 by WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0147
Establishing the Adjusted Weekly Wage

(1) General provisions.

(a) To determine a suitable wage the insurer must first establish the adjusted weekly wage as described in this rule.

(b) The insurer must calculate the adjusted weekly wage whenever determining or redetermining a worker's eligibility for vocational assistance.

(c) All figures used in determining a weekly wage by this method must be supported by verifiable documentation such as the worker's state or federal tax returns, payroll records, or reports of earnings or unemployment insurance payments from the Oregon Employment Department.

(2) Definitions. For the purposes of this rule, the following definitions apply:

(a) "Adjusted weekly wage" is the wage currently paid as calculated under this rule.

(b) "Cost-of-living adjustments" or "collective bargaining adjustments" are increases or decreases in the wages of all workers performing the same or similar jobs for a specific employer. These adjustments are not variations in wages based on skills, merit, seniority, length of employment, or number of hours worked.

(c) "Earned income" means gross wages, salary, tips, commissions, incentive pay, bonuses, and the reasonable value of other consideration (such as housing, utilities, and food) received from all employers for services performed from all jobs held at the time of injury or aggravation. Earned income also means gross earnings from self-employment after deductions of business expenses excluding depreciation. Earned income does not include fringe benefits such as medical, life, or disability insurance, employer contributions to pension plans, or reimbursement of the worker's employment expenses such as mileage or equipment rental.

(d) "Job at aggravation" means the job or jobs the worker held on the date of the aggravation claim or, for a worker not employed at the time of aggravation, the last job or concurrent jobs held before the aggravation. Volunteer work does not constitute a job for purposes of this subsection.

(e) "Job at injury" is the job on which the worker originally sustained the compensable injury. For an occupational disease, the job at injury is the job the worker held at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease.

(f) "Permanent employment" is a job with no projected end date or a job that had no projected end date at the time of hire. Permanent employment may be year-round or seasonal.

(g) "Permanent, year-round employment" is permanent employment in which the worker worked or was scheduled or projected to work in 48 or more calendar weeks a year. Paid leave is counted as work time. Permanent year-round employment includes trial service. It does not include employment with an annual salary set by contract or self-employment.

(h) "Temporary disability" means wage loss replacement for the job at injury.

(i) "Trial service" is employment designed to lead automatically to permanent, year-round employment subject only to the employee's satisfactory performance during the trial service period.

(3) Determining weekly wage. The insurer must determine the nature of the job at injury or the job or jobs at aggravation by contacting the employer or employers to verify the worker's employment status.

(a) When the job at injury or the job at aggravation was temporary or seasonal, calculate the worker's average weekly wage as follows, then convert to the adjusted weekly wage as described in section (4) of this rule:

(A) When the worker's regular employment is the job at injury and the worker did not hold more than one job at the time of injury, and did not receive unemployment insurance benefits during the 52 weeks before the injury, the worker's average weekly wage is the same as the wage upon which temporary disability is based.

(B) When the worker's regular employment is the job at aggravation and the worker did not hold more than one job at the time of aggravation, and did not receive unemployment insurance benefits during the 52 weeks before the aggravation, the worker's average weekly wage is calculated using the same methods used to calculate temporary disability as described in OAR 436-060-0025.

(C) If the worker held more than one job at the time of the injury or aggravation, and did not receive unemployment insurance payments during the 52 weeks before the date of the injury or aggravation, divide the worker's earned income by the number of weeks the worker worked during the 52 weeks before the date of injury or aggravation.

(D) If the worker held one or more jobs at the time of the injury or aggravation, and received unemployment insurance payments during the 52 weeks before the date of the injury or aggravation, combine the earned income with the unemployment insurance payments and divide the total by the number of weeks the worker worked and received unemployment insurance payments during the 52 weeks before the date of the injury or aggravation.

(b) When the job at injury was not seasonal or temporary, use the weekly wage upon which temporary disability was based, and then convert the weekly wage to the adjusted weekly wage as described in section (4) of this rule.

(c) When the job at aggravation was not seasonal or temporary, the worker's average weekly wage is calculated using the same methods used to calculate temporary disability as described in OAR 436-060-0025, and then converting to the adjusted weekly wage as described in section (4) of this rule.

(4) Adjusted weekly wage. After arriving at the worker's weekly wage under section (3), establish the adjusted weekly wage by determining the percentage increase or decrease from the date of injury or aggravation, or last day worked before aggravation, to the date of calculation, as follows:

(a) Contact the employer at injury regarding any cost-of-living or collective bargaining adjustments for workers performing the same job. Adjust the weekly wage by any percentage increase or decrease;

(b) If the employer at injury is no longer in business and the worker's job was covered by a union contract, contact the applicable union for any cost-of-living or collective bargaining adjustments. Adjust the weekly wage by the percentage increase or decrease;

(c) If the employer at injury is no longer in business or does not currently employ workers in the same job category, adjust the weekly wage by the appropriate factor from the cost-of-living matrix in Bulletin 124;

(d) If the worker's regular employment was the employment the worker held at the time of aggravation, adjust the weekly wage by the appropriate factor from the cost-of-living matrix in Bulletin 124.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340(5)(6)
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88, 436-120-0030 Renumbered to 436-120-0075; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0025; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; Renumbered from 436-120-0310, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; Renumbered from 436-120-0007, WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0157
Determining Substantial Handicap to Employment

(1) A counselor must do a substantial handicap evaluation as part of the eligibility evaluation when applicable.

(2) To complete the substantial handicap evaluation the counselor must submit a report documenting the following information about the worker:

(a) Relevant work history for at least the preceding five years;

(b) Level of education, proficiency in spoken and written English or other languages, and achievement or aptitude test data if it exists;

(c) Adjusted weekly wage and suitable wage;

(d) Permanent limitations due to the injury;

(e) An analysis of the worker's transferable skills, if any;

(f) A list of physically suitable jobs for which the worker has the knowledge, skills, and abilities, that pay a suitable wage, and for which a reasonable labor market is documented to exist as described in subsection (g);

(g) An analysis of the worker's labor market using standard labor market reference materials, including but not limited to information provided by the Employment Department's Oregon Labor Market Information System (OLMIS) and Oregon Wage Information (OWI) (available on the Oregon Employment Department's website at www.qualityinfo.org/). When using OWI data, the presumed standard will be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate; and

(h) Consideration of the vocational impact of any limitations that existed before the injury.

(3) When determining the worker's eligibility for vocational assistance, the insurer may consider any knowledge, skills, and abilities the worker gained after the date of injury or aggravation that resulted from training provided by the employer; however, the insurer may not include any knowledge, skills, or abilities the worker gained at his or her own expense after the date of injury or aggravation.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.340(5) & (6)
Hist.: WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; Renumbered from 436-120-0340, WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0165
End of Eligibility for Vocational Assistance

(1) Reasons for ending eligibility. A worker's eligibility for vocational assistance ends when any of the following conditions apply:

(a) Based on new information that did not exist or that could not have been obtained with reasonable effort at the time the insurer determined eligibility, the worker no longer meets the eligibility requirements;

(b) The worker has been employed in suitable employment for at least 60 days after the date of injury or date of aggravation;

(c) The worker has been employed in suitable employment that is modified or new employment resulting from an employer-at-injury activated use of the Preferred Worker Program under OAR 436-110 and:

(A) If there are no worksite modifications, premium exemption has been effective for 12 months;

(B) If there is a worksite modification, 12 months have passed since the director determined it to be complete; or

(C) During the 12-month period in paragraph (A) or (B), the worker is terminated for cause or voluntarily resigns for a reason unrelated to the work injury;

(d) The worker, before beginning an authorized return-to-work plan, refused an offer of suitable employment. If the employer-at-injury offers employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(e) The worker, before beginning an authorized return-to-work plan, left suitable employment after the injury or aggravation for a reason unrelated to the limitations caused by the injury;

(f) The worker, before beginning an authorized return-to-work plan, refused or failed to make a reasonable effort in available light-duty work intended to result in suitable employment. Before ending eligibility, the insurer must document the existence of one or more suitable jobs that would be available for the worker after completion of the light-duty work. If the employer at injury offers such employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(g) The worker, after completing an authorized training plan, refused an offer of suitable employment;

(h) The worker declined or became unavailable for vocational assistance.

(A) The insurer must determine if the reasons are for reasonable or unreasonable cause before ending the worker's eligibility.

(B) If the reason was for incarceration, this reason must be stated in the notice to the worker.

(C) Declining vocational assistance to accept modified or new employment that results from an employer-at-injury activated use of the Preferred Worker Program, under OAR 436-110, is reasonable cause;

(i) The worker refused a suitable training site after the counselor and worker have agreed in writing upon a return-to-work goal;

(j) The worker failed after written warning to participate in the development or implementation of a return-to-work plan. No written warning is required if the worker fails to attend two consecutive training days and fails, without reasonable cause, to notify the counselor or the insurer by the close of the next business day;

(k) The worker's lack of suitable employment cannot be resolved by providing vocational assistance. This includes circumstances in which the worker cannot benefit from, or participate in, vocational assistance because of medical conditions unrelated to the injury;

(l) The worker misrepresented information relevant to providing vocational assistance;

(m) The worker refused after written warning to return property provided by the insurer or reimburse the insurer as required. No vocational assistance will be provided under subsequent openings of the claim until the worker returns the property or reimburses the funds;

(n) The worker misused funds provided for the purchase of property or services. No vocational assistance will be provided under subsequent openings of the claim until the worker reimburses the insurer for the misused funds;

(o) After written warning the worker continues to harass any participant to the vocational process. This subsection does not apply if such behavior is the result of a documented medical or mental condition;

(p) The worker entered into a claim disposition agreement and disposed of vocational rights. The parties may agree in writing to suspend vocational assistance pending approval of the agreement by the Workers' Compensation Board. The insurer must end eligibility when the Workers' Compensation Board approves the claim disposition agreement that disposes of vocational assistance rights. No notice regarding the end of eligibility is required; or

(q) The worker received maximum direct employment services and is not entitled to other categories of vocational assistance.

(2) Notice of end of eligibility. When an insurer ends a worker's eligibility for vocational assistance, the insurer must mail to the worker a NOTICE OF END OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE within five days of the end of eligibility date. The notice must include:

(a) The date when eligibility ended. The effective date is the worker's last date of eligibility; and

(b) The reason the worker's eligibility for vocational assistance is ending. However, notice is not required if the insurer is ending the worker's eligibility because the worker has given up his or her vocational assistance rights through a claim disposition agreement.

(3) Report to director. When an insurer ends a worker's eligibility for vocational assistance, the insurer must submit to the division, within 30 days after the date eligibility ends, Form 2800, "Vocational Closure Report." The report must include:

(a) The effective date for the end of eligibility;

(b) The reason for the end of eligibility; and

(c) Return-to-work and provider information.

Stat. Auth.: ORS 656.340, 656.726(4)

Stats. Implemented: ORS 656.340

Hist.: WCD 11-1982(Temp), f. 12-29-82 eff. 1/1/83; WCD 2-1983, 6-30-83, eff. 6-30-83; WCD 5-1983, 12-14-83, eff. 1-1-84; Renumbered from 436-061-0126, 5-1-85; WCD 7-1985, 12-12-85, eff. 1/1/86; Renumbered from 436-120-0090, WCD 11-1987, 12-17-87, eff. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0045; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04, cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; Renumbered from 436-120-0350 by WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0175
Redetermining Eligibility for Vocational Assistance

If a worker was previously determined ineligible for vocational assistance or the worker's eligibility for vocational assistance ended, the insurer must redetermine eligibility within 30 days of notification of a change of any of these circumstances:

(1) The worker, for reasonable cause, was unavailable for vocational assistance and is now available;

(2) The worker's lack of suitable employment could not be resolved by providing vocational assistance. The insurer may require the worker to provide evidence that circumstances have changed;

(3) The worker declined vocational assistance to accept modified or new employment that resulted from an employer at injury activated use of preferred worker benefits under OAR 436-110. If the job was not suitable, the worker must request redetermination within 30 days of termination of the employment for which preferred worker benefits were provided;

(4) The worker was not available for vocational assistance in Oregon or within commuting distance of Oregon. The worker must request redetermination within six months of receiving the insurer's notice that he or she was not eligible for this reason;

(5) The worker, who was not authorized to work in the United States, is now authorized to work in the United States. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

(a) Request redetermination; and

(b) Submit evidence to the insurer that the worker has applied for authorization to work in the United States and is awaiting a decision by the U.S. Citizenship and Immigration Services (USCIS). The worker must provide the insurer with a copy of any decision by the USCIS within 30 days of receipt. The insurer must redetermine eligibility upon receipt of documentation of the worker's authorization to work in the United States;

(6) Before claim closure, the worker's limitations due to the injury became more restrictive;

(7) Before claim closure, the insurer accepts a new condition that was not considered in the original determination of the worker's eligibility; or

(8) The worker's average weekly wage is redetermined and increased.

Stat. Auth.: ORS 656.340, 656.726(4)

Stats. Implemented: ORS 656.340

Hist.: WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0095; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0055; WCD 23-1996; f. 12-13-96, cert. ef. 2-1-97; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; Renumbered from 436-120-0360 by WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0177
Selection of Category of Vocational Assistance

(1) The insurer must select one of the following categories of vocational assistance before referring a worker to a counselor:

(a) Direct employment services, if the worker has the necessary transferable skills to obtain suitable new employment.

(b) Training, if the worker needs training in order to return to employment that pays a wage significantly closer to 100 percent of the adjusted weekly wage. "Significantly closer" may vary depending on several factors, including, but not limited to: the worker's wage at injury, adaptability, skills, geographic location, limitations, and the potential for the worker's income to increase with time as the result of training.

(2) The insurer must notify the worker of the category selection and the reason for the selection in the NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE issued under OAR 436-120-0115(9).

(3) The insurer must reconsider the category of vocational assistance within 30 days of the insurer's knowledge of a change in circumstances including, but not limited to:

(a) A change in the worker's permanent limitations;

(b) A change in the labor market; or

(c) The category of vocational assistance proves to be inappropriate.

(4) The insurer must notify the worker within five days if the reconsideration under section (3) results in a change in the vocational assistance category.

Stat. Auth.: ORS 656.340(9) & 656.726(4)

Stats. Implemented: ORS 656.340(7)

Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0083 & 0085; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; Renumbered from 436-120-0400, WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0185
Choosing a Counselor

(1) Choosing a counselor.

(a) The insurer and worker must agree on a counselor within 14 days of the worker being determined eligible for vocational assistance.

(b) When the parties agree on a counselor, the insurer must mail the worker a NOTICE OF SELECTION OF VOCATIONAL COUNSELOR.

(c) If the parties do not agree on a counselor, the insurer must notify the division within five days, and the director will select a counselor.

(2) Changing counselors.

(a) If the worker or insurer requests a change in counselor, the insurer and worker must agree on a new counselor within 14 days of the request.

(b) If the parties do not agree on a new counselor, the insurer must refer the matter to the division within five days.

(c) Any time there is a change in counselor, the insurer must mail the worker a NOTICE OF CHANGE OF VOCATIONAL COUNSELOR.

Stat. Auth.: ORS 656.340, 656.726(4)

Stats. Implemented: ORS 656.340
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0111, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0060; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0035; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0330 & 436-120-0370; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; Renumbered from 436-120-0320 by WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0187
Optional Services

(1) Optional services are services provided to:

(a) A worker who is not eligible for vocational assistance; or

(b) A worker who is eligible for vocational assistance, in excess of the services described in these rules.

(2) Optional services are provided at the discretion of the insurer.

(3) The insurer may not use optional services to circumvent the intent of these rules.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0910, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; Renumbered from 436-120-0455, WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0197
Direct Employment

(1) Direct employment services, generally.

(a) Direct employment services may include, but are not limited to:

(A) Employment counseling;

(B) Job search skills instruction, which teaches workers how to write resumes, research the job market, locate suitable new employment, complete employment applications, interview for employment, and develop other skills related to obtaining suitable new employment;

(C) Job development with related return-to-work activities, which helps the worker contact appropriate prospective employers; and

(D) Job analysis.

(b) If the insurer determines the worker is entitled to direct employment services, the insurer must provide the worker with at least four months of direct employment services.

(c) A direct employment plan must include a description of the worker's transferable skills that relate to the vocational goals and a discussion of why training will not bring the worker a wage significantly closer to 100 percent of the adjusted weekly wage at the time of injury.

(d) Direct employment services must be provided by a counselor.

(e) Direct employment services must begin on the date the insurer approves a direct employment plan, or on the completion date of an authorized training plan.

(f) If the insurer does not approve a direct employment plan within 45 days of determining the worker entitled to a direct employment plan, the insurer must contact the division within five days to schedule a conference.

(A) The purpose of the conference will be to identify and remove all obstacles to plan completion and approval.

(B) The insurer, the worker, the counselor, and any other parties involved in the process must attend the conference.

(C) The conference may be postponed for a period of time agreed on by the parties.

(D) The insurer or the worker may request a conference if other delays in the process occur.

(g) The insurer must provide return-to-work follow-up for at least 60 days after the worker becomes employed to ensure the work is suitable and to provide any necessary assistance that enables the worker to continue the employment.

(2) Responsibilities in direct employment plan.

(a) The worker is responsible for the following in a direct employment plan:

(A) Maintain regular contact with the counselor;

(B) Fully participate in plan services;

(C) Follow up on all job leads in a timely manner;

(D) Be an active participant in the job search;

(E) Accept suitable employment if it is offered and notify the counselor immediately;

(F) Promptly inform the counselor of any problems that might affect participation in the plan; and

(G) Meet any responsibilities agreed to in the plan.

(b) The counselor is responsible for the following in a direct employment plan:

(A) Provide instruction on job-search skills, as necessary;

(B) Provide job development, as necessary;

(C) Provide timely, accurate progress reports to the insurer; and

(D) Meet any responsibilities agreed to in the plan.

(3) Plan amendments.

(a) If the vocational goal is later changed, the insurer must amend the direct employment plan. All amendments to the plan must be initialed by the insurer, counselor, and worker.

(b) If the insurer amends a proposed plan, the insurer must indicate what the changes are and why they are necessary.

(4) Reporting to the director. The direct employment plan and any amendments must be submitted to the division within five days of plan approval using Form 1083, "Direct Employment Plan."

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0060, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0030; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0075 & 436-120-0083; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; Renumbered from 436-120-0430, WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0410
Determining a Vocational Goal

A counselor must determine a suitable vocational goal for the worker using one or more of the following:

(1) Vocational testing. Vocational testing must be administered by an individual certified to administer the test.

(2) Job analysis. A job analysis is a detailed description of the physical and other demands of a job based on direct observation of the job.

(3) On-the-job evaluation. An on-the-job evaluation must evaluate a worker's work traits, aptitudes, limitations, potentials, and habits in an actual job environment.

(a) The counselor must perform a job analysis to determine if the job is within the worker's capacities. The insurer must submit the job analysis to the attending physician if there is any question about the appropriateness of the job.

(b) The evaluation should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

(c) The evaluation does not establish any employer-employee relationship.

(d) A written report must evaluate the worker's performance in the areas originally identified for assessment.

(4) Labor market search.

(a) A labor market search is obtained from direct contact with employers, other actual labor market information, or from other surveys completed within 90 days of the report date.

(b) A labor market search is needed when standard labor market reference materials do not have adequate information upon which to base a decision, or there are questions about a worker's specific limitations, training, and skills that must be addressed with employers to determine if a reasonable labor market exists.

(c) The person providing the information must have hiring responsibility or direct knowledge of the job's requirements and the job must exist at the firm contacted.

(d) The labor market search report must include, but is not limited to:

(A) Date of contact;

(B) Firm name, address, and telephone number;

(C) Name and title of person contacted;

(D) Qualifications of persons recently hired;

(E) Physical requirements;

(F) Wages paid;

(G) Condition of hire (full-time, part-time, seasonal, temporary);

(H) Date and number of last hire(s); and

(I) Available and anticipated openings.

(e) Specific openings found in the course of a labor market search are not, in themselves, proof a reasonable labor market exists.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef 1-1-95, Renumbered from 436-120-0081; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0420; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0443
Training — General

(1) Training services include but are not limited to plan development, training, monthly monitoring of training progress, and job placement services.

(2) The training plan must be developed and monitored by a counselor.

(3) The selection of plan objectives and the kind of training must attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment.

(4) If there are any changes made to the original training plan, an addendum to Form 1081, "Training Plan," must be completed, signed by all parties, and submitted to the division.

(5) Basic education may be offered, with or without other training components, to raise the worker's education to a level to enable the worker to obtain suitable employment.

(6) On-the-job training prepares the worker for permanent, suitable employment with the training employer and for employment in the labor market at large. On-the-job training must be considered first in developing a training plan.

(7) Occupational skills training is offered through a community college, based on a predetermined curriculum, at the training employer's location.

(8) Formal training may be offered through a vocational school licensed by an appropriate licensing body, community college, or other post-secondary educational facility that is part of a state system of higher education.

(9) Rehabilitation facilities training provides evaluation, training, and employment for severely disabled individuals.

(10) Notwithstanding OAR 436-120-0145(2)(b), the director may order the insurer, or the insurer may elect, to provide training outside Oregon if such training would be more timely, appropriate, or cost effective than other alternatives.

(11) Training status continues during the following breaks:

(a) A regularly scheduled break of not more than six weeks between fixed school terms;

(b) A break of not more than two weeks between the end of one kind of training and the start of another for which the starting date is flexible; or

(c) A period of illness or recuperation of the worker that does not prevent completion of the training by the planned date.

(12) The insurer must pay the worker temporary disability compensation, under ORS 656.268 and 656.340, when the worker is actively engaged in an approved training plan and there is a Form 1081, "Training Plan," signed by the worker, the insurer, and the counselor who developed the plan.

(13) Temporary disability compensation is limited for each eligibility period to 16 months unless extended to 21 months by the insurer or ordered by the director when the worker provides good cause. Good cause may include but is not limited to the reasons given under section (14) of this rule. In no event may temporary disability compensation during training be paid for more than 21 months.

(14) Training costs may be paid for periods longer than 21 months. Reasons for extending training may include but are not limited to:

(a) Reasons beyond the worker's control;

(b) The worker has an exceptional disability, which is a disability equal to or greater than the complete loss, or loss of use, of both legs, or a brain injury that results in impairment equal or greater than Class 3 as defined in OAR 436-035-0390; or

(c) The worker has an exceptional loss of earning capacity, which exists when no suitable training plan of 18 months or less will eliminate the worker's substantial handicap to employment. The extension must allow the worker to obtain, at the time of completion of the training program, a wage that is as close as possible to the worker's adjusted weekly wage and greater than could be expected with a shorter training program.

(15) An eligible worker is entitled to four months of job placement assistance after completion of training.

(16) When the worker returns to work following training, the insurer must monitor the worker's progress for at least 60 days to assure the suitability of the employment before ending eligibility.

(17) If the worker chooses a training plan period of longer than he or she is entitled to receive under these rules, the worker may supplement training provided by the insurer by completing self-sponsored training or studies. For the purpose of this rule, self-sponsored means the worker is obligated to pay for the training.

(a) The first day of training provided by the insurer will be considered the training start date and the last day of training provided by the insurer will be the training end date.

(b) All self-sponsored training must be completed before the training start date unless the parties otherwise agree.

(c) During self-sponsored training, the insurer may provide optional services under OAR 436-120-0187, including but not limited to payment of expenses for tuition, fees, books, and supplies.

(d) The training plan support document must describe how the worker-sponsored training and the training provided by the insurer will combine to prepare the worker for suitable employment.

(18) The insurer must provide further training to a worker if the initial plan will not be or was not successful to prepare the worker for suitable employment.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; Renumbered from 436-061-0060, WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; Renumbered from 436-120-0030, WCD 11-1987, f. 12-17-87, ef. 1-1-88; Renumbered from 436-120-0075 & 436-120-0085, WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0450 & 436-120-0460,WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; Renumbered from 436-120-0440, WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 9-2013, f. 11-12-13, cert. ef. 1-1-14; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0445
Training Requirements

(1) Basic education. Basic education is limited to nine months unless extended by the insurer.

(2) On-the-job training.

(a) On-the-job training time is limited to 12 months unless extended by the insurer.

(b) The insurer must reimburse the training employer for a portion of the worker's wages.

(c) The on-the-job training contract between the training employer, the insurer, and the worker must include, but is not limited to:

(A) The worker's name;

(B) The employer's legal business name;

(C) The employer's current workers' compensation insurance policy number;

(D) The name of the individual providing the training;

(E) The training plan start and end dates;

(F) The job title and duties;

(G) The skills to be taught;

(H) The base wage and the terms of wage reimbursement;

(I) An agreement that the employer will pay all taxes normally paid on the entire wage and will maintain workers' compensation insurance for the trainee; and

(J) An acknowledgement that the training may not prepare the worker for jobs elsewhere, if the training prepares a worker for a job unique to the training site.

(d) The insurer must pay temporary disability compensation as provided in ORS 656.268.

(e) Unless there is a need to accommodate the worker's documented medical condition or class schedule, the worker's schedule must be the same as for a regular full-time employee.

(3) Occupational skills training.

(a) Occupational skills training is limited to 15 months unless extended by the insurer.

(b) The training is primarily for the worker's benefit. The worker may not receive wages.

(c) Training does not establish any employer-employee relationship with the training employer. The training employer makes no guarantee of employing the worker when the training is completed.

(d) The training employer has a sufficient number of employees to accomplish its regular work and the training of the worker, and the worker does not displace an employee.

(e) Unless there is a need to accommodate the worker's documented medical condition or class schedule, the worker's schedule must be the same as for a regular full-time employee.

(4) Formal training.

(a) Formal training time is limited to 18 months unless extended by the insurer.

(b) Course load must be consistent with the worker's abilities and limitations and the length of time since the worker last attended school.

(c) Courses must relate to the vocational goal.

(5) Training before eligibility determined. If the worker begins or completes training between the date of injury and the date of the eligibility determination, and then the insurer finds the worker eligible for vocational assistance and finds the worker's training suitable, the insurer must reimburse the worker for costs required by that training and verified by the insurer or the director, including temporary disability as required under ORS 656.268 and 656.340.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; Renumbered from 436-061-0060, WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; Renumbered from 436-120-0030, WCD 11-1987, f. 12-17-87, ef. 1-1-88; Renumbered from 436-120-0075 & 436-120-0085, WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0450 & 436-120-0460,WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; Renumbered from 436-120-0440, WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0500
Training: Development and Implementation

(1) Collaborative effort. A training plan should be a collaborative effort between the counselor and the worker and should include all the rights and responsibilities of the worker, the insurer, and the counselor.

(2) Review of the plan. Before submitting the plan to the insurer, the counselor must review the plan and plan support with the worker. The worker must have the opportunity to review the plan with the worker's attorney, if any, before signing it. The counselor must confirm the worker's understanding of and agreement with the plan by obtaining the worker's signature.

(3) Copies of plan. The counselor must submit copies of the plan, signed by the counselor and the worker, to all parties.

(4) Plan approval or disapproval. Within 14 days of receipt of the signed training plan, the insurer must approve or disapprove the plan and notify the parties.

(a) If the insurer does not have enough information to approve or disapprove the training plan, the insurer must advise the parties what information is needed and when the insurer expects to make a decision.

(b) If the insurer disapproves the training plan, the insurer must issue a NOTICE OF DISAPPROVAL OF TRAINING PLAN, which must explain why the plan is disapproved.

(5) Conference. If the insurer does not approve a training plan within 90 days of determining the worker is entitled to a training plan, the insurer must contact the division within five days to schedule a conference.

(a) The purpose of the conference will be to identify and remove all obstacles to plan completion and approval.

(b) The insurer, the worker, the counselor, and any other parties involved in the process must attend the conference.

(c) The conference may be postponed for a period of time agreeable to the parties.

(d) The insurer or the worker may request a conference if other delays in the vocational rehabilitation process occur.

(6) Job offer during plan development. If, during development of a training plan, an employer offers the worker a job, the insurer must perform a job analysis, obtain approval from the attending physician, verify the suitability of the wage, and confirm the offer is for a bona fide, suitable job. If the job is suitable, the insurer must help the worker return to work with the employer. The insurer must provide return-to-work follow-up during the first 60 days after the worker returns to work. If return to work with the employer is not feasible or, during the 60-day follow-up the job proves unsuitable, the insurer must immediately resume development of the training plan.

(7) Plan amendments.

(a) If the vocational goal is later changed, the insurer must amend the training plan. All amendments to the plan must be initialed by the insurer, counselor, and the worker.

(b) If the insurer amends a proposed plan, the insurer must indicate what the changes are and why they are necessary.

(8) Reporting to the director. The training plan and any amendments must be submitted to the division using Form 1081, "Training Plan."

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(9)
Hist.: WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0172, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from OAR 436-120-0105 & 436-120-0170; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 23-1996, f. 12-13-96, cert. ef. 2-1-97; Renumbered from 436-120-0600, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0510
Training Plan Support

(1) Considerations in training plan. The worker and counselor must work together to develop an appropriate training plan that considers the worker's:

(a) Transferable skills;

(b) Physical and mental capacities and limitations;

(c) Vocational interests;

(d) Educational background and academic skill level;

(e) Pre-injury wage; and

(f) Place of residence and that labor market.

(2) Training plan documentation. Training plan supporting documentation must contain, but is not limited to, the following:

(a) Specific vocational goals and projected return-to-work wages;

(b) A description of the worker's current medical condition, relating the worker's permanent limitations to the vocational goals;

(c) A description of the worker's education and work history, including job durations, wages, Standard Occupational Classification (SOC) codes or other standardized job titles and codes, and specific job duties. The SOC codes can be found on the Oregon Employment Department OLMIS website at www.qualityinfo.org;

(d) An explanation of why direct employment services will not return the worker to suitable employment;

(e) A summary of the results of any evaluations or testing. If the results do not support the goals, the counselor must explain why the goals are appropriate;

(f) A summary of current labor market information that shows the labor market supports the vocational goals and documents that the worker has been informed of the condition of the labor market;

(g) A labor market search as prescribed in 436-120-0410(4), if needed;

(h) If the labor market information does not support the goals, the counselor must explain why the goals are appropriate. The worker and worker's representative, if any, must acknowledge in writing an awareness of the poor labor market conditions and a willingness to proceed with the plan in spite of these conditions. This acknowledgment must include an understanding the insurer will provide no additional training should the worker be unable to find suitable employment because of the labor market;

(i) A job analysis prepared by the counselor, signed by the worker and by the attending physician or a qualified facility designated by the attending physician, and based on a visit to a worksite comparable to what the worker could expect after completing training. If the attending physician is unable or unwilling to address the job analysis and does not designate a facility as described above, the insurer may submit the job analysis to a qualified facility of its choice. The insurer must submit the resulting information to the attending physician for concurrence. If the attending physician has not responded within 30 days of the date of request for concurrence, the plan may proceed;

(j) A signed on-the-job training contract, if applicable;

(k) A description of the curriculum, which must be term-by-term if the curriculum is for formal training;

(l) Information about the payment of temporary disability compensation while the worker is in training. If the training plan is for a longer period of time than temporary disability benefits may be paid, the plan must notify the worker that temporary disability benefits may end before training ends; and

(m) If material related to a plan is contained in a previous eligibility, the insurer may attach a copy of the evaluation to the plan.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94,cert. ef. 1-1-95; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0105; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0520
Responsibilities of the Worker and the Counselor

(1) Worker responsibilities. The worker is responsible for all of the following in a training plan:

(a) Actively participate in all aspects of the plan;

(b) Maintain regular contact with the counselor throughout plan development and as required in the plan;

(c) Notify the counselor if problems develop and continue to attend training during attempts to resolve the issue;

(d) Inform the counselor immediately if anything threatens to interfere with successful completion of the program;

(e) Notify the counselor by the close of the next working day if the worker stops attending training for any reason;

(f) Maintain a 2.0 grade point average each grading period in formal training;

(g) Complete the courses outlined in the curriculum by the plan end date;

(h) Consult with the counselor before adding or dropping courses;

(i) Provide a written training report to the counselor by the fifth day of each month;

(j) Give the counselor a copy of each grade or progress report within 10 days of receipt; and

(k) Meet all responsibilities agreed to in the plan.

(2) Counselor responsibilities. The counselor is responsible for all of the following in a training plan:

(a) During plan development, provide resource materials about jobs, training programs (if appropriate), labor markets and other related information to help the worker select a vocational goal; direct information gathering; and otherwise help the worker analyze and evaluate options;

(b) Help the worker plan the curriculum and enroll. The counselor must contact the worker, trainers, and training facility counselors to the extent necessary to assure the worker's participation and progress;

(c) Contact the worker on a regular basis;

(d) Monitor and evaluate the plan at least monthly;

(e) Contact the worker's trainers and training site counselors, as necessary to ensure the worker's participation and progress meet the requirements of the rules and are satisfactory to achieve the return-to-work objectives;

(f) Report potential problems in the program to the insurer immediately including additional needs of the worker;

(g) Advise the insurer within one business day of learning of any circumstance indicating a probable or actual interruption in the worker's entitlement to temporary disability benefits;

(h) Provide job-search skills and job development as necessary; and

(i) Meet any responsibilities agreed to in the plan.

Stat. Auth.: ORS 656.340(9) & 656.726(4)

Stats. Implemented: ORS 656.340

Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0115; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; DEQ 11-2016, f. & cert. ef. 11-2-16

436-120-0523
Re-evaluating a Training Plan

(1) Reasons to re-evaluate a plan. The insurer must re-evaluate a training plan and modify or replace the plan when appropriate to ensure the worker's success, when:

(a) A change occurs in the worker's limitations that may make the training inappropriate; or

(b) In an academic program:

(A) There is an indication the worker may not maintain at least a 2.0 grade point average for two grading periods; or

(B) There is an indication the worker may not complete the minimum credit hours required under the training plan.

(2) Academic program. In an academic program:

(a) The counselor must notify the insurer, and the insurer may give the worker a written warning of the possible end of training, when the worker:

(A) Fails to maintain a 2.0 grade point average for two consecutive grading periods; or

(B) Fails to complete the minimum credit hours in the training plan curriculum.

(b) If the insurer is going to end training for a reason listed in subsection (a), the worker must be given a written warning before training is ended.

(3) Non-academic program. In a non-academic program, the counselor must notify the insurer, and the insurer may give the worker a written warning of the possible end of training, at the first indication that the worker's performance in training is unsatisfactory and may not result in employment in that field.

Stat. Auth.: ORS 656.340(9) & 656.726(4)

Stats. Implemented: ORS 656.340(7)

Hist.: WCD 11-1982(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983, f. & ef. 6-30-83; WCD 5-1983, f. 12-14-83, ef. 1-1-84; 5-1-85; Renumbered from 436-061-0060, WCD 7-1985, f. 12-12-85, ef. 1-1-86; Renumbered from 436-120-0030, WCD 11-1987, f. 12-17-87, ef. 1-1-88; Renumbered from 436-120-0075 & 436-120-0085, WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0450 & 436-120-0460,WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; Renumbered from 436-120-0440, WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; Renumbered from 436-120-0447, WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; Renumbered from 436-120-0448, WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0527
Ending a Training Plan

(1) Reasons to end training. Training ends when:

(a) The worker has successfully completed training;

(b) The worker's eligibility for vocational assistance has ended under OAR 436-120-0165;

(c) The worker is not actively engaged in the training;

(d) The worker fails, after written warning, to maintain at least a 2.0 grade point average for two consecutive grading periods;

(e) The worker fails, after written warning, to complete the minimum credit hours in the training plan curriculum for two consecutive grading periods;

(f) In a non-academic program, the worker's performance in training is unsatisfactory and further training is not likely to result in employment in that field; or

(g) The training plan was not going to be successful due to reasons beyond the worker's control.

(2) Notice of end of training. When training ends, the insurer must mail a NOTICE OF END OF TRAINING to the worker. The notice must:

(a) Include the date the training plan ended. The effective date is the worker's last date of attendance; and

(b) State whether the worker is entitled to more training.

Stat. Auth.: ORS 656.340(9) & 656.726(4)

Stats. Implemented: ORS 656.340(7)

Hist.: WCD 11-1982(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983, f. & ef. 6-30-83;WCD 5-1983, f. 12-14-83, ef. 1-1-84; 5-1-85; Renumbered from 436-061-0060, WCD 7-1985, f. 12-12-85, ef. 1-1-86; Renumbered from 436-120-0030, WCD 11-1987, f. 12-17-87, ef. 1-1-88; Renumbered from 436-120-0075 & 436-120-0085, WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0450 & 436-120-0460,WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; Renumbered from 436-120-0440, WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; Renumbered from 436-120-0447, WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; Renumbered from 436-120-0451, WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0530
Director Review of Return-to-Work Plan

The director may review return-to-work plans and supporting information. If the director finds a return-to-work plan or its supporting information does not conform to these rules:

(1) The director will notify the insurer and provider in writing of the preliminary finding of nonconformance. The notification will inform the insurer of changes or information required to bring the plan into conformance.

(2) The insurer must, within 30 days of notification, make appropriate changes, supply additional information requested by the director, or explain why no change should be made.

(3) If the insurer does not respond timely or is unable to bring the plan into conformance, the director will return the plan to the parties with notification that the plan does not conform to OAR 436-120 and may order the insurer to develop a plan that conforms to the rules.

Stat. Auth.: ORS 656.340(9) & 656.726(4)

Stats. Implemented: ORS 656.340

Hist.: WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0172, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0170 & 436-120-0215; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0700
Direct Worker Purchases

(1) Purchases, generally.

(a) The insurer must provide the direct worker purchase categories listed in OAR 436-120-0710 as necessary for the worker's participation in vocational assistance and to meet the requirements of a suitable job.

(b) The worker is no longer eligible for these purchases once eligibility ends unless the purchases are necessary to complete a plan.

(c) Direct worker purchases include partial purchase, lease, rental, and payment.

(2) Exclusions. Direct worker purchases do not include:

(a) Purchases of real property;

(b) Payment of fines or other penalties; or

(c) Payment of additional driver's license costs, increased insurance costs, or any other costs attributable to problems with the worker's driving record.

(3) Alternative purchases. In making its decision regarding a direct worker purchase, the insurer may choose the least expensive, adequate alternative. If the worker wants a direct worker purchase that is more expensive than that authorized by the insurer, the worker may select that alternative and pay the difference in cost.

(4) Approval or denial. Within 14 days of its receipt of a request for a direct worker purchase, the insurer must approve the purchase or notify the worker of its denial.

(5) Payment. The insurer must pay for approved direct worker purchases in time to prevent delay in the provision of services, but in no event later than 30 days after the insurer receives the worker's request or proof of payment, whichever is later.

(6) Advancement of costs, worker reimbursement. The worker may pay for mileage, child or senior care, or for purchases such as clothing, books, and supplies or the worker may request an advance of any of these costs based on documentation of need.

(a) The insurer must reimburse costs within 30 days of receiving a written request from the worker and any supporting documentation.

(b) The insurer must return denied requests for reimbursement to the worker within 30 days of receiving the request with an explanation of the reason for nonpayment.

(7) Right and title to nonexpendable purchases. The insurer must assign to the worker right and title to the nonexpendable direct worker purchases paid by the insurer.

(a) The insurer must make such assignment no later than the 60th day of continuous employment unless the worker remains eligible and the suitability of the employment is in question.

(b) The insurer may repossess nonexpendable property if the worker no longer requires the property for training or employment.

(c) The insurer may require repayment of advancements or reimbursements if the worker misrepresented information material to the purchase decision or if the worker used the funds for something other than the approved purchase.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0087; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0710
Direct Worker Purchases: Categories

The insurer must provide the direct worker purchases listed in this rule if necessary for the worker to participate in vocational assistance or to meet the requirements of a suitable job. The insurer may not require the worker to submit a financial statement in order to qualify for direct worker purchases.

(1) Tuition, fees, books, and supplies. Payment for tuition, fees, books, and supplies for training or studies is limited to those items identified as mandatory by the instructional facility, trainer, or employer. The insurer must pay the cost in full, and may not require the worker to apply for grants to pay for tuition, books, or other expenses associated with training.

(2) Wage reimbursement. The amount of wage reimbursement for on-the-job training must be agreed to in a contract between the training employer and the insurer.

(3) Travel expenses. Travel expenses for transportation, meals, and lodging that are required for participation in vocational assistance, including but not limited to job search, required meetings with the counselor, and meetings with employers or at training sites as required by the plan or plan development. The conditions and rates for payment of travel expenses are as follows:

(a) Transportation costs will be paid at public transportation rates when public transportation is available; otherwise, mileage will be paid at the rate published in Bulletin 112. Costs incidental to mileage, such as parking fees, also will be paid. For workers receiving temporary total disability or equivalent income, private car mileage will be paid only for mileage in excess of the miles the worker traveled to and from work at the time of injury. Mileage payment in conjunction with moving expenses will be allowed only for one vehicle and for a single one-way trip. To receive reimbursement for private car mileage, the worker must provide the insurer with a copy of the driver's valid driver's license and proof of insurance coverage.

(b) For overnight travel, meal and lodging expenses will be reimbursed at the rate published in Bulletin 112.

(c) Payment for special travel costs will be made in excess of the amounts specified in this section when special transportation or lodging is necessary because of the physical needs of the worker, or when the insurer finds prevailing costs in the travel area are substantially higher than average.

(4) Tools and equipment. Payment for tools and equipment for training or employment is limited to items identified as mandatory for the training or initial employment, such as starter sets. Purchases may not include what the trainer or employer ordinarily would provide to all employees or trainees in the training or employment, or what the worker already owns.

(5) Moving expenses. Payment for moving expenses is limited to workers with employment or training outside reasonable commuting distance. In determining the necessity of paying moving expenses, the insurer may consider the availability of employment or training that does not require moving, or that requires less than the proposed moving distance. Payment is limited to moving household goods weighing not more than 10,000 pounds. If necessary, payment includes reasonable costs of meals and lodging for the worker's family and mileage under section (3) of this rule.

(6) Second residence allowance. The purpose of the second residence allowance is to enable the worker to participate in training outside reasonable commuting distance. The allowance must equal the rental expense reasonably necessary, plus not more than $200 a month toward all other expenses of the second residence, excluding refundable deposits. In order to qualify for second residence allowance, the worker must maintain a permanent residence.

(7) Primary residence allowance. The primary residence allowance applies when the worker must change residence for training or employment. Payment includes the first month's rent and the last month's rent only if required before moving in.

(8) Medical and psychological examinations. Payment for medical examinations and psychological examinations must be for conditions not related to the compensable injury when necessary for determining the worker's ability to participate in vocational assistance.

(9) Physical or work capacities evaluations.

(10) Living expense allowance. Payment for living expenses is limited to workers involved in a vocational evaluation at least five hours daily for four or more consecutive days, and not receiving temporary disability payments. The worker will not be barred from receiving a living expense allowance if the worker is unable to participate five hours daily because of limitations caused by the injury. Payment must be based on the worker's temporary total disability rate if the worker's claim were reopened.

(11) Work adjustment, on-the-job evaluation, or situational assessment costs.

(12) Membership fees and occupational certifications, licenses, and related testing costs. Payment for membership fees, occupational certifications and licenses, and related testing costs is limited to $500.

(13) Clothing. Clothing purchases may not include items the trainer or employer would provide or the worker already possesses.

(14) Child or disabled adult care services. Child or disabled adult care services are payable when required to enable the worker to participate in vocational assistance at rates prescribed by the Oregon Department of Human Services. For workers receiving temporary total disability compensation or equivalent income, these costs will be paid only when in excess of what the worker paid for such services at the time of injury, adjusted using the cost-of-living matrix in Bulletin 124.

(15) Dental work, eyeglasses, hearing aids, and prosthetic devices. Payment for dental work, eyeglasses, hearing aids, and prosthetic devices is required even if not related to the compensable injury if they will enable the worker to obtain suitable employment or participate in training.

(16) Union dues and fees. Payment for labor union dues and fees is limited to initiation fees, or back dues and one month's current dues.

(17) Vehicle rental or lease. Payment for vehicle rental or lease is required when there is no reasonable alternative enabling the worker to participate in vocational assistance or accept an available job. The worker must provide the insurer with proof of a valid driver's license and insurance coverage. Payment is limited to $1,000.

(18) Other purchases. Payment for other purchases the insurer considers necessary for the worker's participation in vocational assistance is limited to $1,000.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0087; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 5-2012, f. 10-3-12, cert. ef. 11-1-12; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0720
Fee Schedule

(1) The director has established the fee schedule in section (3) of this rule for professional costs and direct worker purchases. The schedule sets maximum spending limits per claim opening for each category; however, the insurer may spend more than the maximum limit. Spending limits will be adjusted annually, effective July 1, based on the conversion factor described in OAR 436-120-0005 and published with the cost-of-living matrix in Bulletin 124.

(2) For workers needing an extended training plan under OAR 436-120-0443, the fee schedule spending limits for the Training category and Direct Employment/Training Combined category listed below must be increased by 30 percent.

(3) Amounts include professional costs, travel and wait time, and other travel expenses: [Table not included. See ED. NOTE.]

NOTE: *Each limit is shown as a percentage of Oregon's state average weekly wage (SAWW), determined under ORS 656.211. Dollar amounts are published in Bulletin 124 and are adjusted annually, effective July 1, based on changes in the SAWW.

(4) The insurer must pay, within 30 days of receipt, the provider's bill for services provided under the insurer-provider agreement. The insurer may not deny payment on the grounds the worker was not eligible for the assistance if the provider performed the services in good faith without knowledge of the ineligibility.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340 & 656.258
Hist.: WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0120, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88 ; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0070 & 436-120-0215; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0755
Reimbursement from the Workers' Benefit Fund

(1) Reimbursement. The director will reimburse the insurer for costs associated with providing vocational benefits when:

(a) The director issues an order overturning the insurer's denial of vocational benefits; and

(b) The insurer's denial is later upheld by a final order.

(2) Required documentation. To receive reimbursement from the Workers' Benefit Fund, the insurer must provide the division with the following documentation, within one year from the date of the final order:

(a) Worker's name and Workers' Compensation Division's claim file number;

(b) Date and order number of the director's order appealed;

(c) Itemized listing with dates of service for all costs incurred after the date of the director's order that was reversed. All costs, in order to be reimbursed, must meet all conditions set forth in these rules, and reimbursement requests must:

(A) Use terms, "direct employment" or "training" to show the category of vocational assistance provided;

(B) List provider costs by category of "professional services";

(C) List direct worker purchases by the categories in OAR 436-120-0710, and include purchase dates and costs;

(D) Show temporary total disability paid between the start and end dates of the return to work plan; and

(E) List any other costs incurred in providing vocational benefits as a result of the order that was appealed.

(d) Signed statement certifying that the requested reimbursement amount was actually paid; and

(e) The insurer's name and address where reimbursement is to be sent.

(3) Administrative costs not reimbursable. No reimbursement is allowed for the insurer's administrative costs.

Stat. Auth.: 656.726(4)
Stats. Implemented: ORS 656.313, 656.605, OL 2005, Ch. 588, sec. 4 & 5
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0800
Registration of Providers

(1) A provider may not provide vocational assistance services unless the provider is first registered by the director under this rule.

(2) A provider must submit an application, Form 2814, "Vocational Assistance Certification Program Registration of Vocational Assistance Provider," to the division that includes a description of the specific vocational services to be provided and verification of staff certifications under these rules.

(3) The director may approve or deny registration based on the completed application and the department's registration and counselor certification records.

(a) The registration will specify the scope of authorized vocational services as determined by the provider's staff certifications.

(b) Providers whose registration is denied under this rule may appeal as described in OAR 436-120-0008.

(4) A registered provider must:

(a) Notify the division within 30 days of any changes in office address, telephone number, contact person, or staff; and

(b) Maintain worker vocational assistance files for four years after the end of vocational assistance with that provider.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 8-1981(Admin) (Temp), f. 12-31-81, ef. 1-1-82; WCD 9-1982(Admin), f. 5-28-82, ef. 6-1-82; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0180, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-061-0200 & 436-120-0203; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0810
Certification and Classification of Provider Staff

(a) Individuals determining workers' eligibility and providing vocational assistance must be certified by the director and on the staff of a provider.

(b) An applicant for certification must submit Form 1880, "Vocational Assistance Certification Program Individual Certification Under OAR 436-120," to the division.

(c) All degrees required for certification must be from an accredited institution and copies of transcripts must be submitted with the application.

(d) If the director approves the application, certification will be granted for five years. A counselor who is nationally certified as described in subparagraph (3)(a)(B)(i) will be granted an initial certification period to coincide with the counselor's national certification.

(e) Certified individuals must notify the division within 30 days of any changes in address or telephone number.

(f) An individual whose certification is denied under this rule may appeal as described in OAR 436-120-0008.

(2) Classification of provider staff. Certified individuals will be classified as follows:

(a) Vocational assistance counselor;

(b) Vocational assistance intern; or

(c) Return-to-work specialist.

(3) Certification requirements. The requirements for certification as a counselor, intern, or specialist are as follows:

(a) Vocational assistance counselor.

(A) Certification as a counselor allows the individual to determine eligibility for vocational assistance and provide vocational assistance services.

(B) Counselor certification requires:

(i) Certification by one of the following national certifying organizations:

(I) The Commission on Rehabilitation Counselor Certification (CRCC);

(II) The Commission for Case Managers Certification (CCMC); or

(III) The Certification of Disability Management Specialists Commission (CDMSC);

(ii) A master's degree in vocational rehabilitation counseling and at least six months of direct experience;

(iii) A master's degree in psychology, counseling, or a field related to vocational rehabilitation, and 12 months of direct experience; or

(iv) A bachelor's or higher degree and 24 months of direct experience. Thirty-six months of direct experience may substitute for a bachelor's degree.

(C) To meet the direct experience requirements for a counselor, the individual must:

(i) Perform return-to-work plan development and implementation for the required number of months; or

(ii) Perform three or more of the qualifying job functions listed in sub-subparagraphs (I) through (X) for the required number of months, with at least six months of the experience in one or more of the functions listed in sub-subparagraphs (I) through (IV). The qualifying job functions are:

(I) Return-to-work plan development and implementation;

(II) Employment counseling;

(III) Job development;

(IV) Early return-to-work assistance that includes working directly with workers and their employers;

(V) Vocational testing;

(VI) Job search skills instruction;

(VII) Job analysis;

(VIII) Transferable skills assessment or employability evaluations;

(IX) Return-to-work plan review and approval; or

(X) Employee recruitment and selection for a wide variety of occupations.

(b) Vocational assistance intern.

(A) Certification as a vocational assistance intern allows the individual to determine eligibility for vocational assistance and provide vocational assistance services under the direct supervision of a counselor. A counselor must co-sign and assume responsibility for all of the intern's actions.

(B) Intern certification requires:

(i) A master's degree in psychology, counseling, or a field related to vocational rehabilitation; or

(ii) A bachelor's degree and at least six hours of training on the Oregon vocational assistance and re-employment assistance rules. Thirty-six months of direct experience may substitute for a bachelor's degree.

(C) To meet the direct experience requirements for an intern, the individual must:

(i) Perform return-to-work plan development and implementation for the required number of months; or

(ii) Perform three or more of the qualifying job functions listed in subparagraph (3)(a)(C)(ii) of this rule for the required number of months.

(c) Return-to-work specialist.

(A) Certification as a return-to-work specialist allows the individual to provide job search skills instruction, job development, return-to-work follow-up, and labor market search, and to determine eligibility for vocational assistance except when the determination requires a judgment as to whether the worker has a substantial handicap to employment.

(B) Specialist certification requires 24 months of direct experience. Full-time (or the equivalent) additional college coursework in psychology, counseling, education, a field related to human services, or a field related to vocational rehabilitation may substitute for up to 18 months of direct experience, on a month-for-month basis.

(C) The direct experience requirements for a specialist are the same for an intern, as described in paragraph (b)(C) of this section.

(d) To receive credit for the direct experience requirements, the individual must:

(A) Perform one or more of the qualifying job functions listed in subparagraph (3)(a)(C)(ii) of this rule at least 50 percent of the work time for each month of direct experience credit. Qualifying job functions performed in a job that is less than full-time will be prorated. For purposes of this rule, full-time is 40 hours a week. An individual will not receive credit for any function performed less than 160 hours.

(B) Provide any documentation required by the director, including work samples. The director may also require verification by the individual's past or present employers.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0205; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0820
Renewal of Certification

(1) Required documentation. A certified individual must renew his or her certification every five years by submitting the following documentation to the division no later than 30 days before the end of the certification period:

(a) Current certification by the Commission on Rehabilitation Counselor Certification (CRCC), the Commission for Case Managers Certification (CCMC), or the Certification of Disability Management Specialists Commission (CDMSC); or

(b) Verification of a minimum of 60 hours of continuing education units under this rule within the five years before renewal.

(2) Continuing education.

(a) The director will accept continuing education units for:

(A) Training approved by the CRCC, CCMC, or CDMSC;

(B) Courses in or related to psychology, sociology, counseling, or vocational rehabilitation, if given by an accredited institution of higher learning;

(C) Training presented by the division pertaining to OAR 436-120, 436-105, or 436-110;

(D) Teaching a class or making a formal presentation to a group on a topic related to vocational rehabilitation; and

(E) Any continuing education program certified by the director for providers. Sixty minutes of continuing education will count as one unit, except as noted in subsection (b) of this section.

(b) In the case of college course work, the director will grant credit only for grades of C or above and will multiply the number of credit hours by six to establish the number of continuing education units.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 5-2010, f. 9-15-10, cert. ef. 11-15-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0840
Professional Standards for Providers and Counselors

(1) Providers and counselors must:

(a) Determine eligibility and provide assistance in an objective manner not subject to any conditions other than those prescribed in these rules;

(b) Fully inform the worker of the categories and kinds of vocational assistance under OAR 436-120 and re-employment assistance under OAR 436-110;

(c) Document all case activities in legible file notes or reports;

(d) Provide only vocationally relevant information about workers in written and oral reports;

(e) Recommend workers only for suitable employment;

(f) Fully inform the worker of the purpose and results of all testing and evaluations; and

(g) Comply with generally accepted standards of conduct in the vocational rehabilitation profession.

(2) Providers and counselors may not:

(a) Provide evaluations or assistance if there is a conflict of interest or prejudice concerning the worker;

(b) Enter into any relationship with the worker to promote personal gain or the gain of a person or organization in which the provider or counselor has an interest;

(c) Engage in or tolerate sexual harassment of a worker. "Sexual harassment" means deliberate or repeated comments, gestures, or physical contact of a sexual nature;

(d) Violate any applicable state or federal civil rights law;

(e) Commit fraud, misrepresent, or make a serious error or omission in connection with an application for registration or certification;

(f) Commit fraud, misrepresent, or make a serious error or omission in connection with a report or return-to-work plan or the vocational assistance activities or responsibilities of a provider under OAR chapter 436;

(g) Engage in collusion to withhold information, or submit false or misleading information relevant to the determination of eligibility or provision of vocational assistance;

(h) Engage in collusion to violate these rules or other rules of the department, or any policies, guidelines, or procedures issued by the director;

(i) Fail to comply with an order of the director to provide specific vocational assistance, except as provided in ORS 656.313; or

(j) Instruct any individual to make decisions or engage in behavior that is contrary to the requirements of these rules.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.313, 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0207; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0900
Audits, Penalties and Sanctions

(1) Insurers and employers at injury must fully participate in any department audit, periodic program review, investigation, or review, and provide records and other information as requested.

(2) If the director finds the insurer or employer at injury failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

(b) Recovery of reimbursements;
(c) Denial of reimbursement requests; or
(d) A civil penalty under ORS 656.745.
(3) In determining the amount of a civil penalty to be assessed the director may consider:
(a) The degree of harm inflicted on the worker;
(b) Whether there have been previous violations or warnings; and
(c) Other matters as justice may require.
Stat. Auth.: ORS 656.340 & 656.726(4)
Stats. Implemented: ORS 656.340, 656.447 & 656.745(1) & (2)
Hist.: WCD 4-1981, f. 12-4-81, ef. 1-1-82; WCD 2-1983, f. 6-30-83, ef. 6-30-83; WCD 5-1983, f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0981, 5-1-85; WCD 7-1985, f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, eff. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0255 & 436-120-0270; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-17

436-120-0915
Sanctions of Providers and Counselors
(1) Providers and counselors must fully participate in any department audit, periodic program review, investigation, or review, and provide records and other information as requested.
(2) If the director finds any provider or counselor failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:
(a) Reprimand by the director;
(b) Probation, in which the department systematically monitors the provider's or counselor's compliance with OAR 436-120 for a specified length of time. Probation may include the requirement a counselor receive supervision or successfully complete specified training, personal counseling, or drug or alcohol treatment;
(c) Suspension, which is the termination of registration or certification to determine eligibility and provide vocational assistance to Oregon injured workers for a specified period of time. The provider or counselor may reapply for registration or certification at the end of the suspension period. If granted, the provider or counselor will be placed on probation as described in subsection (2)(b) of this rule; or
(d) Revocation, which is a permanent termination of registration or certification to determine eligibility and provide vocational assistance to Oregon injured workers.
(3) The director will investigate violations of OAR 436-120 and may impose a sanction under these rules. Before issuing a suspension or revocation, the director will send a notice of the proposed action and provide the opportunity for a show-cause hearing as follows:
(a) The director will send by certified mail a written notice of intended suspension or revocation and the grounds for such action. The notice must advise of the right to participate in a show-cause hearing.
(b) The provider or counselor has 10 days from the date of receipt of the notification of proposed action in which to request a show-cause hearing.
(c) If the provider or counselor does not request a show-cause hearing, the proposed suspension or revocation will become final.
(d) If the provider or counselor requests a show-cause hearing, the director will send a notification of the date, time, and place of the hearing.
(e) After the show-cause hearing, the director will issue a final order that may be appealed as described in OAR 436-120-0008(3).
(4) For the purposes of section (3) of this rule, "show-cause hearing" means an informal meeting with the director in which the provider or counselor will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a provider or counselor's authority to provide vocational assistance services to injured workers.
(5) The director may bar a provider or counselor who has received a suspension or revocation under this rule from sponsoring or teaching continuing education programs.
Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, eff. 1-1-88; Renumbered from 436-120-0207, WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0850, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 4-2016, f. 11-28-16, cert. ef. 1-1-1

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Rule Caption: Amendments to rules governing workers' compensation insurance and self-insurance
Adm. Order No.: WCD 5-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 10-1-2016
Rules Amended: 436-050-0003, 436-050-0005, 436-050-0008, 436-050-0015, 436-050-0025, 436-050-0040, 436-050-0045, 436-050-0050, 436-050-0055, 436-050-0110, 436-050-0120, 436-050-0150, 436-050-0160, 436-050-0165, 436-050-0170, 436-050-0175, 436-050-0180, 436-050-0190, 436-050-0195, 436-050-0200, 436-050-0205, 436-050-0210, 436-050-0220, 436-050-0230, 436-050-0260, 436-050-0270, 436-050-0280, 436-050-0290, 436-050-0300, 436-050-0340, 436-050-0400, 436-050-0410, 436-050-0420, 436-050-0440, 436-050-0450, 436-050-0455, 436-050-0460, 436-050-0470, 436-050-0480, 436-050-0185
Rules Repealed: 436-050-0001, 436-050-0002, 436-050-0006, 436-050-0060
Subject: The agency has amended OAR 436-050, "Employer/Insurer Coverage Responsibility," to:
- Improve the clarity of the rules through improved organization, plain language, repeal of obsolete provisions, and definition of terms;
- Explain the applicability of rules to self-insured employer groups;
- Complete implementation of Senate Bill 1558 (2014) by establishing standards for acceptable financial viability of self-insured employers, primarily by:
-- Requiring a self-insured employer to demonstrate acceptable financial strength equal to "strong" or "moderate" under the rules;
-- Requiring a self-insured employer to submit financial reports to the director that contain information sufficient to calculate the financial ratios described in the rules;
- - Describing the financial ratios that will be used to determine a self-insured employer's financial strength; and
-- Explaining how the financial ratios will be used to determine the self-insured employer's financial strength;
- Clarify procedures for requesting administrative review by the director;
- Clarify procedures for show-cause hearings regarding suspension or revocation of an insurer's authorization to renew or issue workers' compensation policies;
- Specify that in determining compliance with the limitation on the number of claims processing locations, the insurer or self-insured employer must count each physical location and where its claims are processed or its records maintained as one location;
- Require the insurer or self-insured employer to give the director notice of an email address for each claims processing location;
- Clarify that the director must approve a service agreement before the service company begins processing the insurer's, self-insured employer's, or self-insured employer group's claims in Oregon, regardless of the agreement's effective date;
- Require the insurer or self-insured employer to notify the estates of deceased workers and any beneficiaries receiving benefits under a claim when the insurer changes claims processing location or service company;
- Specify the claim information that must be sent to the director when only a portion of an insurer's claims will be transferred to a new processing location or service company;
- Explain that failure to provide proper notice of a change in claims processing location or service company may result in the assessment of a civil penalty against the insurer or self-insured employer;
- Specify that each location where a service company processes an insurer's or self-insured employer's claims counts as one of the insurer's or self-insured employer's allowed claims processing locations;
- Clarify claims record-keeping requirements for insurers and self-insured employers;
- Specify that an ISLOC or surety bond must be issued under the legal name or assumed business name of the self-insured employer as registered with the Oregon Secretary of State;

- Require that a self-insured employer must submit proposed changes in the retention level and policy limits of an excess insurance policy at least 30 days before the effective date of the change;

- Require a self-insured employer to include in its report of losses separate lists that include all claims with total incurred losses above and below the National Council on Compensation Insurance split point published in Bulletin 209;

- Provide that the values determined at audit will be used to calculate the self-insured employer's security deposit, experience rating factor, and retrospective rating adjustment;

- Describe additional criteria the director will use to determine a self-insured employer's required deposit;

- Allow a self-insured employer to submit a certified actuarial study (subject to some limitations) for determination of the security deposit amount;

- Specify that a self-insured employer may not transfer claims to any excess insurer or service company acting on behalf of an excess insurer for the processing of the employer's claims;

- Provide that, if given probable cause, the director may order a self-insured employer who is exempt from providing a security deposit to increase the amount of its loss reserve account, and that the self-insured employer must comply within 30 days of the director's order;

- Provide that if a self-insured employer submits a request to cancel self-insurance certification fewer than 60 days before the desired date of cancellation, the actual termination date may be later than the date requested;

- List required elements of the service agreement between a self-insured employer and a service company;

- Provide that a self-insured employer may add an amount to its security deposit equal to what is required for a common claims fund instead of maintaining a common claims fund; and

- Provide that a self-insured employer group is not required to create a common claims fund in any year in which the director applies an incurred but not reported factor of greater than zero percent in the determination of the self-insured employer group's security deposit.

Rules Coordinator: Fred Bruyns—(503) 947-7717

436-050-0003

Applicability and Purpose of these Rules

(1) Purpose. These rules carry out the workers' compensation law related to employers' and insurers' responsibilities to cover subject workers for compensable injuries and illnesses.

(2) Applicability. The requirements of OAR 436-050-0165, 436-050-0170, 436-050-0175, 436-050-0180, 436-050-0190, 436-050-0200, 436-050-0205, 436-050-0210 and 436-050-0220 apply to both self-insured employers and self-insured employer groups. References in those rules to "employer" include employer groups, and references to "self-insured employer" include self-insured employer groups.

(3) Director's discretion. The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth: ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.017, 656.029, 656.126, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.443, 656.447, 656.455, 656.745, 656.850, 656.855, 731.475

Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 10-1982(Admin), f. 9-30-82, ef. 10-1-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; Renumbered from 436-051-0003, 1-1-86; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 1-2013(Temp), f. & cert. ef. 1-23-13 thru 7-21-13; WCD 5-2013, f. 7-3-13, cert. ef. 7-22-13; WCD 8-2013, f. 11-12-13, cert. ef. 1-1-14; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 13-2014, f. 11-26-14, cert. ef. 1-1-15; WCD 10-2015, f. 12-24-15, cert. ef. 1-1-16; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0005

Definitions

Unless a term is defined elsewhere in these rules, the definitions of ORS chapter 656 are incorporated by reference and made a part of these rules. For the purpose of these rules, unless the context requires otherwise:

(1) "Assigned claims agent" means an entity selected by the director to process the claims of a non-complying employer under ORS 656.054.

(2) "Audited financial statement" means a financial statement audited by an outside accounting firm.

(3) "Cancel" or "cancellation" in relation to an insurance policy means ending the policy at a date before its expiration date.

(4) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(5) "Controlling person" means a person having substantial ownership or who is an officer or director of a corporation; a member or manager of a limited liability company; a partner of a partnership; or an individual who has, directly or indirectly, the power to direct or cause the direction of the management, policies, or operation of a person offering worker leasing services.

(6) "Days" means calendar days unless otherwise specified.

(7) "Default" means failure of an employer, insurer, or self-insured employer to pay the moneys due the director under ORS 656.506, 656.612, and 656.614 at such intervals as the director directs.

(8) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(9) "Governmental subdivision" means cities, counties, special districts defined in ORS 198.010, intergovernmental agencies created under ORS 225.050, school districts as defined in ORS 255.005, public housing authorities created under ORS chapter 456, or regional council of governments created under ORS chapter 190.

(10) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(11) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon.

(12) "Leased worker" means any worker provided by a worker leasing company on other than a "temporary basis" as described in OAR 436-050-0420.

(13) "Nonrenewal" means the insurer's decision not to renew a policy at its expiration date.

(14) "Person" means an individual, partnership, corporation, joint venture, limited liability company, association, government agency, sole proprietorship, or other business entity allowed to do business in the state of Oregon.

(15) "Premium" means the monetary consideration for an insurance policy.

(16) "Premium assessments" means moneys due the director under ORS 656.612 and 656.614.

(17) "Process claims" is the determination of compensability and management of compensation by an Oregon certified claims examiner.

(18) "Proof of coverage" has the same meaning as defined in OAR 436-162-0005.

(19) "Reinstatement" means the continuation or reestablishing of workers' compensation insurance coverage, as noted by the effective date of the reinstatement, under a workers' compensation insurance policy that was previously canceled.

(20) "Renewal" or "renew" means the issuance of a policy succeeding a previously issued policy or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date.

(21) "Self-insured employer" means an employer who has been certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

(22) "Self-insured employer group" means five or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407 and OAR 436-050-0260 through 436-050-0340.

(23) "Service company" means the contracted agent for an insurer, self-insured employer, or self-insured employer group authorized to process claims and make payment of compensation on behalf of the insurer, self-insured employer, or self-insured employer group.

(24) "State" means the State of Oregon.

(25) "Substantial ownership" means a percentage of ownership equal to or greater than the average percentage of ownership of all the owners, or ten percent, whichever is less.

(26) "Worker leasing company" means a "person," as described in section (14) of this rule, who provides workers, by contract and for a fee, as established in ORS 656.850.

(27) "Written" means information communicated in writing, and includes electronic records.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.726(4)
Hist.: WCB 2-1976(Admin)(Temp), f. & ef. 4-12-76; WCB 3-1976(Admin), f. & ef. 6-15-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 10-1982(Admin), f. 9-30-82, ef. 10-1-82; WCD 1-1983(Admin), f. 6-30-83, ef. 7-1-83; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0005; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0008
Requests for Hearings or Administrative Review

(1) Request for hearing on an action concerning a worker's right to compensation. Any party, or assigned claims agent, that disagrees with an action taken under these rules that concerns a worker's right to compensation, or the amount of compensation due, may request a hearing by the Hearings Division under ORS chapter 656 and OAR chapter 438.

(2) Request for hearing on proposed sanctions or civil penalties. Any party, or assigned claims agent, that disagrees with a proposed order, or proposed assessment of civil penalty, of the director issued under ORS 656.254, 656.735, 656.745, or 656.750 may request a hearing by the Hearings Division. To request a hearing the party or assigned claims agent must:

(a) Mail or deliver a written request to the Workers' Compensation Division within 60 days of the mailing date of the proposed order or assessment; and

(b) Specify, in the request, the reasons why the party or assigned claims agent disagrees with the proposed order or assessment.

(3) Request for administrative review. Any party, or assigned claims agent, that disagrees with an action taken under these rules other than as described in section (1) of this rule may request the director to conduct an administrative review of the action.

(a) To request administrative review, the party or assigned claims agent must:

(A) Mail or deliver a written request for review to the Workers' Compensation Division within 90 days of the contested action; and

(B) Specify, in the request, the reasons why the party or assigned claims agent disagrees with the action.

(b) Requests mailed more than 90 days after the contested action may be considered if the director determines there was good cause for delay, or that substantial injustice may otherwise result.

(4) Request for hearing on an action not concerning a worker's right to compensation. Any party, or assigned claims agent, that disagrees with an action or order of the director under these rules other than as described in section (1) or (2) of this rule may request a hearing by filing a request under OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth: ORS 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.254, 656.735, 656.740, 656.745 & 656.750
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; Renumbered from 436-051-0998, 1-1-86; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-87; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0015
Suspension and Revocation of Authorization to Issue Workers' Compensation Insurance Policies

(1) General. The director may suspend or revoke an insurer's authorization to issue or renew workers' compensation insurance policies upon a determination that:

(a) The insurer has failed to comply with its obligations under any workers' compensation policy; or

(b) The insurer has failed to comply with ORS chapter 656, OAR chapter 436, or the orders of the director.

(2) Show-cause hearings. The director will not suspend or revoke an insurer's authorization to issue or renew workers' compensation insurance policies until the insurer has been given notice and the opportunity to be heard through an informal show-cause hearing with the director.

(a) During the show-cause hearing, the insurer will be provided an opportunity to:

(A) Present evidence regarding any proposed orders by the director to suspend or revoke the insurer's authorization to issue or renew workers' compensation insurance policies; and

(B) Give reason why the insurer should be permitted to continue to issue and renew workers' compensation insurance policies.

(b) Following the show-cause hearing, the director may rescind a proposed order of suspension or revocation if the insurer establishes to the director's satisfaction its ability and commitment to comply with ORS chapter 656 and OAR chapter 436.

(3) Suspension of authorization to issue workers' compensation insurance policies. If the director suspends an insurer's authorization to issue workers' compensation insurance policies:

(a) The suspension may be in effect for a period of up to 18 months;

(b) The suspended insurer may continue to serve existing accounts and renew any existing policy, unless there is a cancellation or nonrenewal of the policy during the period of suspension; and

(c) The director may audit the performance of the insurer during the period of suspension, and:

(A) If the insurer is in compliance, the director may lift the suspension; or

(B) If the insurer is not in compliance, and the suspension has been in effect for at least 12 months, the director may revoke the insurer's authorization to renew or issue workers' compensation insurance policies.

(4) Revocation of authorization to issue workers' compensation insurance policies. If the director revokes an insurer's authorization to issue or renew workers' compensation insurance policies:

(a) The insurer may serve an existing account only until the policy is canceled or until the next renewal date, whichever first occurs; and

(b) The insurer may petition the director to restore the insurer's authorization by submitting a plan demonstrating its ability and commitment to comply with ORS chapter 656, OAR chapter 436, and the orders of the director.

(5) Appeal and revision of orders of suspension or revocation. Any proposed and final orders of suspension or revocation issued under this rule is a preliminary order subject to revision by the director, and may be appealed under OAR 436-050-0008.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.447
Hist.: WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0025
Service of the Notice of Civil Penalty Orders

When the director issues a civil penalty order, it will be served by certified mail, return receipt requested, or in any other manner provided by Oregon Rules of Civil Procedure (7)(D) available at: https://www.oregonlegislature.gov/bills_laws/Pages/orcp.aspx. Proof of service may include a hard copy signed receipt or electronic verification.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.704, 656.726, 656.740
Hist.: WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0040
Responsibility for Providing Coverage When a Contract is Awarded

(1) If a person, including a person that is a sole proprietorship, that is responsible to provide coverage for an individual performing labor under ORS 656.029, fails to comply with ORS 656.017, that person is considered a noncomplying employer.

(2) As used in ORS 656.029, "the performance of labor where such labor is a normal and customary part or process of the person's trade or business" includes the day-to-day activities or operations which are necessary to successfully carry out the business or trade.

(3) A person contracting to pay remuneration for professional real estate activity as defined in ORS chapter 696, to a qualified real estate broker as defined in ORS 316.209, is not an employer of the qualified real estate broker, and is not required to provide coverage under ORS 656.017.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.029 & 656.037
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0052; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0045
Non-Subject Workers

For the purposes of clarifying terms used in ORS 656.027:

(1) A "worker engaged in household domestic service by private employment contract" includes a worker in the direct employment of the

owner of the private home. As used in this rule, "owner of the private home" means:

(a) Any person who occupies and owns, leases, or rents the private home;

(b) Any person related by blood, marriage, or Oregon registered domestic partnership to that person; or

(c) Any person who, by direction of that person or by order of a court, has become responsible for managing the household affairs of that person;

(2) A "person performing foster parent duties" means:

(a) Any person certified as a foster parent by the Oregon Department of Human Services under ORS chapter 418; or

(b) Any person employed by the foster parent in the operation of a foster home as defined in ORS chapter 418; and

(3) A "person performing adult foster care duties" means:

(a) Any person operating an adult foster home licensed under ORS 443.705 to 443.825; or

(b) Any person employed by the operator to perform services that assist the residents of the adult foster home.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.027

Hist.: WCD 7-1991(Temp), f. 10-4-91, cert. ef. 10-7-91; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0050

Corporate Officers, Partnerships; Limited Liability Company Members; Subjectivity

(1) A corporation, limited liability company, or partnership may elect to provide workers' compensation coverage for otherwise nonsubject workers:

(a) The election must be made in writing to the insurer at the beginning of a coverage policy and remain in effect until a revised written designation is given to the insurer;

(b) A self-insured employer must file the election with the director.

(2) If an entity does not file its initial election, or is not in compliance under ORS 656.017 and 656.407, then those exempt individuals will be determined in the following order:

(a) For a corporation:

(A) President;

(B) Secretary, if any;

(C) Vice President, if any;

(D) Secretary/Treasurer, if any;

(E) Treasurer, if any;

(F) All other officers, if any; or

(b) For a limited liability company or partners of a partnership:

(A) The member or partner with the largest ownership interest;

(B) The member or partner with the next largest ownership interest; and

(c) If more than one person is in the same office, or more than one member or partner have equal ownership interest, the sequence of those persons will be determined by whose birthday falls earlier in a year.

(3) Noncomplying corporations, noncomplying limited liability companies, or noncomplying partnerships, regardless of the number of employees, are limited to two exempt officers, members, or partners to be determined in accordance with section (2) of this rule.

(4) For purposes of clarifying terms used in ORS 656.027:

(a) "Commercial harvest of timber" means all commercial activities relating to harvest of timber from a parcel of property including, but not limited to, road building, marking of trees to be cut, timber falling, slash removal, and transportation of timber to the location where it will be processed into lumber or other products; and

(b) "Director" means a person elected or appointed to a corporation's board of directors in accordance with its articles of incorporation or bylaws.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.027

Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; Renumbered from 436-051-0065, 1-1-86; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 8-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 7-1991(Temp), f. 10-4-91, cert. ef. 10-7-91; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0055

Extraterritorial Coverage

(1) For the purposes of determining whether a worker is temporarily in or out of state under ORS 656.126, the director will use criteria including, but not limited to, the following:

(a) The extent to which the worker's work within the state is of a temporary duration;

(b) The intent of the employer regarding the worker's employment status;

(c) The understanding of the worker regarding the employment status with the employer;

(d) The permanent location of the employer and its permanent facilities;

(e) The circumstances and directives surrounding the worker's work assignment;

(f) The state laws and regulations to which the employer is otherwise subject;

(g) The residence of the worker;

(h) The extent to which the employer's work in the state is of a temporary duration, established by a beginning date and expected ending date of the employer's work; and

(i) Other information relevant to the determination.

(2) Within 30 days after coverage of an Oregon employer is effective, the insurer providing the coverage must notify the employer in writing of the provisions of ORS 656.126 and this rule.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.126

Hist.: WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0110

Notice of Insurer's Place of Business in State; Coverage Records Insurer Must Keep in Oregon

(1) Claims processing locations. Every insurer that is authorized to issue workers' compensation policies to Oregon subject employers must comply with the following:

(a) The insurer may not process or maintain records of claims subject to ORS chapter 656 at any location outside of this state;

(A) The insurer may receive claim reports at locations outside of the state as long as claims are forwarded to an Oregon location for processing; and

(B) Payments may be made from outside of the state as directed from the Oregon location;

(b) The insurer may not have more than eight locations at any time where its claims are processed or its claims records are maintained. The insurer must count each physical location where it processes claims or maintains records as one location; and

(c) The insurer must give the director notice of the location, mailing address, telephone number, email address, and any other contact information requested by the director, of any location in this state where the insurer processes claims or keeps written records of claims and proof of coverage as required by ORS 731.475;

(A) The information provided in the notice must reasonably lead an inquirer to:

(i) A person who can respond to inquiries regarding workers' compensation insurance policy, claim filing, and claims processing location information; and

(ii) An Oregon certified claims examiner who can respond to reasonable claims processing inquiries within 48 hours, not including weekends or legal holidays;

(B) The notice must also include contact information for:

(i) A designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director;

(ii) A designated person or position within the company who can respond to workers' compensation policy and proof of coverage filing inquiries; and

(iii) A company email address that is monitored on a regular basis, where the director can direct general inquiries; and

(C) The notice must be filed with the director not more than 30 days after the insurer becomes authorized and starts writing workers' compensation insurance policies for Oregon subject employers.

(2) Service companies. If an insurer elects to use one or more service companies with respect to all or any portion of its business:

(a) The insurer must provide the director with a copy of the agreement between the insurer and each service company, and must give the director notice of the location and mailing address of each service company;

(b) The director must approve the service agreement before the service company begins processing the insurer's claims in Oregon, regardless of the agreement's effective date;

(c) To be approved, the service agreement must:

(A) Be between the underwriting insurer and a service company that is incorporated in or authorized to do business in Oregon, and must not be between any other third parties;

(B) Identify the insurer by company name, or if multiple insurers related by ownership, by the name of the group if it includes all affiliates;

(C) Identify the service company by name;

(D) Grant the service company a power of attorney to act for the insurer in workers' compensation coverage and claims proceedings under ORS chapter 656; and

(E) Contain only those provisions for workers' compensation activities that are allowed in Oregon. The director may approve an agreement that contains provisions for activities not allowed in Oregon if the agreement or an addendum provides that any services or provisions not allowed under Oregon workers' compensation law will not be applied when processing Oregon claims. The director may require existing agreements that contain provisions for activities not allowed in Oregon to be amended accordingly; and

(d) The insurer must count each service company that processes the insurer's claims as one of the eight claims processing locations allowed under subsection (1)(b) of this rule. Each service company at a physical location must be counted as a separate claims processing location.

(3) Changes in place of business. If the insurer or its service company will change its primary place of business or contact information, the insurer must notify the director of the new location, mailing address, telephone number, email address, and any other contact information at least 30 days before the effective date of the change.

(4) Changes in claims processing locations. If an insurer changes claims processing locations or service companies:

(a) At least 10 days before the change is effective, the insurer must provide notice of the change, and provide the name of a contact person for, telephone number, email address and mailing address of the new location to:

(A) Any worker, or the estate of any deceased worker, with an open or active claim that will be processed at the new location;

(B) Each worker's attorney, if any;

(C) Each worker's attending physician; and

(D) Any beneficiaries receiving benefits under the claims;

(b) At least 10 days before the change is effective, the insurer must provide notice to the director of which claims will be transferred. The notice to the director must include:

(A) A contact person, telephone number, email address, and mailing address for both the sending processor and receiving processor of the claims;

(B) The physical address where the claims will be processed;

(C) Verification of whether the claims to be transferred include closed claims;

(D) If only a portion of the insurer's claims will be transferred, a listing of the claims being transferred that identifies:

(i) The underwriting insurer;

(ii) The employer;

(iii) The claimant's name;

(iv) The date of injury; and

(v) The sending processor's claim number; and

(E) Any other information requested by the director; and

(c) If the insurer does not provide notice as required by this section, the director may assess a civil penalty against the insurer.

(5) Activities required to be conducted at in-state locations. The following activities must be conducted at a designated in-state location by an authorized representative of the insurer:

(a) Processing claims for compensation;

(b) Responding to specific claims processing inquiries;

(c) Maintaining records required under OAR 436-050-0120;

(d) Accommodating periodic audits by the director; and

(e) Any other activity necessary to meet the requirements of ORS chapter 656 and OAR chapter 436.

Stat. Auth.: ORS 731.475, 656.726(4)

Stats. Implemented: ORS 731.475

Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 6-1984(Admin), f. & ef. 9-14-84; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0205; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0120

Records Insurers Must Keep in Oregon; Removal and Disposition

(1) Claims records insurers must keep in Oregon. Each insurer is required to keep the following records of claims for compensation in this state and make those records available to the director upon request:

(a) Written records used and relied upon in processing claims;

(b) A written record of all payments made as a result of any claim including documentation of:

(A) The amount of the payment;

(B) The date the payment was issued;

(C) The date the payment was mailed or delivered; and

(D) An explanation of the time period between the date the payment was issued and the date the payment was mailed or delivered, if any;

(c) Written records of the approval or denial of claims for supplemental temporary disability benefits under ORS 656.210(5);

(d) Written records of the insurer that show its insured employers have complied with ORS 656.017; and

(e) Written records, or copies of records, of claims processed by prior service companies.

(2) Claims records the insurer may remove from Oregon. An insurer may remove the following records, under the conditions described in this section:

(a) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial has been affirmed by operation of law.

(b) Records of any claim for a compensable injury, including a denied claim that is found to be compensable, may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(3) Destruction of claims records. The insurer may destroy claims records when the insurer can verify that all potential for benefits to the worker or the worker's beneficiaries is gone.

(4) Proof of coverage records insurer must keep in Oregon. The records relating to proof of coverage that insurers are required to keep in the state include:

(a) A written record of each workers' compensation insurance policy and related endorsements, reinstatements, or cancellations issued as required under the workers' compensation law;

(b) Written records of premiums due and premiums collected by the insurer from its insured employers as a result of coverage issued under the workers' compensation law; and

(c) Written records that segregate and show specifically for each employer the amounts due from the employer and all such money collected and paid by the insurer for premiums for insurance coverage, premium assessments, and any other moneys due the director or required to be paid to the director.

(5) Disposal of proof of coverage records. If all payments have been made, proof of coverage records may be disposed of after the later of:

(a) The next examination of the insurer by the Division of Financial Regulation under ORS 731.300; or

(b) January 1 of the year following three calendar years after the cancellation or nonrenewal of the workers' compensation insurance policy.

Stat. Auth.: ORS 731.475, 656.726(4)

Stats. Implemented: ORS 731.475

Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0215; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0150

Qualifications of a Self-Insured Employer

(1) General qualifications. To qualify as a self-insured employer, the employer must:

(a) Establish proof that the employer has an adequate staff qualified to process claims;

(b) Establish proof of the financial ability to make certain the prompt payment of all compensation and other payments due under ORS chapter 656;

(c) Obtain excess insurance coverage in the amounts approved by the director; and

(d) Be registered and authorized to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable, or be a municipal or public corporation as defined in ORS 297.405.

(2) Claims processing staff. The employer must establish proof of an adequate staff qualified to process claims by:

(a) Employing and retaining at each claims processing location, at least one claims examiner that is certified under OAR 436-055-0070 to process claims in this state, and is actually involved in the claims processing function; or

(b) Contracting the services of one or more service companies that employ at each claims processing location in this state, at least one claims examiner that is certified under OAR 436-055-0070 to process claims in this state, and that is actually involved in processing the self-insured employer's claims.

(3) Proof of financial ability. Unless exempt under OAR 436-050-0185, the employer must establish proof of financial ability by:

(a) Providing a security deposit that the director determines is acceptable under OAR 436-050-0165, and in an amount as determined under OAR 436-050-0180; and

(b) Demonstrate acceptable financial strength by maintaining a rating equal to "strong" or "moderate" as determined under sections (4) and (5) of this rule.

(4) Financial strength analysis. The financial reports submitted by the employer under OAR 436-050-0175(1) must contain information sufficient to calculate the financial ratios described in this section. The points awarded for each ratio will be used to determine the employer's financial strength under section (5) of this rule.

(a) For the purposes of calculating the financial ratios under this section:

(A) The face value of a self-insured employer's irrevocable standby letter of credit (ISLOC) used to satisfy the director's requirement for a security deposit may not be included in the self-insured employer's reported assets;

(B) Current assets include all assets that may be reasonably expected to be converted into cash, or could become the equivalent of cash, within one year in the normal course of business;

(i) Current assets include, but are not limited to cash, accounts receivable, inventory, and prepaid expenses, and investments, marketable securities, and bonds that mature within one year or may be converted to cash without penalties or fees; and

(ii) Current assets must not include fixed assets, accumulated depreciation, intangible assets, or investments, marketable securities, or bonds with maturity dates of one year or longer;

(C) Current liabilities are debts and obligations expected to be due within the next year;

(i) Examples of current liabilities include accounts payable, notes payable, accrued taxes, and wages and salaries owed to workers;

(ii) Current liabilities must not include debts or claims on assets that will be due a year or more in the future or longer-term liabilities;

(D) Long-term liabilities must include all debts and obligations expected to be due one year or more in the future. Long-term liabilities include any mortgages, loans, bonds, and claims reserve funds not due within one year;

(E) Net assets are total assets less total liabilities. Financial statements and reports may otherwise refer to net assets as net position, adjusted net worth, surplus, owner's equity, or shareholders' equity; and

(F) Net income is the net revenue from sales, interest, or services rendered minus costs, operating expenses, and taxes. Financial statements and reports may otherwise refer to this component as comprehensive income, net earnings, or net profit;

(b) The current ratio is calculated by dividing current assets by current liabilities. A maximum of six points are possible for the current ratio, to be awarded as follows: [Table not included. See ED. NOTE.]

(c) The debt-to-equity ratio is calculated by dividing long-term liabilities by net assets. A maximum of six points are possible for the debt-to-equity ratio, to be awarded as follows: [Table not included. See ED. NOTE.]

(d) The return-on-net assets ratio is calculated by dividing net income by net assets. A maximum of six points are possible for the return-on-net-assets ratio, to be awarded as follows: [Table not included. See ED. NOTE.]

(5) Rating of financial strength. The employer's financial strength will be rated based on the sum of the points awarded for the three ratios under section (4) of this rule.

(a) A sum of 13 to 18 points is equal to a strong rating:

(A) The director will approve initial or continued certification if the employer meets all of the requirements of this rule; and

(B) The employer's security deposit amount will be determined based on OAR 436-050-0180(1) or (3);

(b) A sum of 7 to 12 points is equal to a moderate rating:

(A) The director will approve initial or continued certification if the employer meets all the requirements of this rule; and

(B) The employer's security deposit amount will be determined based on OAR 436-050-0180 (1) and (2), or (3); and

(c) A sum of 0 to 6 points is equal to a weak rating:

(A) The director may not approve the application for initial self-insured employer certification; and

(B) For an existing certified self-insured employer, the director may:

(i) Provide the employer notice of the director's intent to revoke its self-insurance certification under OAR 436-050-0200 and this rule;

(ii) Increase the security deposit calculated under OAR 436-050-0180 by an amount based on factors including, but not limited to, the considerations identified in OAR 436-050-0180(4); or

(iii) Allow the amount of the security deposit to be determined based on a certified actuarial study under OAR 436-050-0180(3); or

(iv) Request that the employer submit a financial correction plan that demonstrates the employer's ability to improve its rating, in a reasonable time period, without hampering the employer's ability to pay compensation and other amounts due under ORS chapter 656;

(6) Failure to maintain qualifications. Failure of a certified self-insured employer to maintain the qualifications required in this rule may result in revocation of the employer's self-insured certification. If the director intends to revoke the employer's self-insured employer's certification:

(a) The director will give the employer 30 days written notice;

(b) The revocation will be effective 30 days from the date the employer receives the director's revocation notice; and

(c) If the employer complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

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

Stat. Auth.: ORS 656.407, 656.704 & 656.726(4)

Stats. Implemented: ORS 656.407

Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0305; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 8-2003(Temp), f. & cert. ef. 7-18-03 thru 1-13-04; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0160

Applying for Certification as a Self-Insured Employer

(1) Required information. An employer applying for certification as a self-insured employer must submit:

(a) A completed Form 1868, "Application for Self-Insurance;"

(b) Proof of an adequate staff qualified to process the employer's claims under OAR 436-050-0150(2);

(c) The employer's audited financial statements or audited annual reports for the last three fiscal or calendar years, subject to the following:

(A) If the audited financial statements of a parent company are provided in place of statements for the employer, the director will not authorize the individual employer to be self-insured under its own program, unless a parental company guarantee can be obtained. Otherwise, it will be necessary for the parent company to be the self-insured employer or to separately insure the employer. In the context of this section, a parent company is a legal entity that owns a majority interest in the employer, or owns a majority interest in another entity or succession of entities that own a majority interest in the employer; or

(B) If audited financial statements are not available at the time of application, the employer may submit certified financial statements in place of audited financial statements or annual reports. However, if the certified financial statements submitted are insufficient to evaluate the employer's financial ability, the director may require the employer to submit audited financial statements;

(d) The employer's most recent experience rating modification worksheet and supporting documentation. Applicants with prior Oregon experience who do not submit this data will be assigned a 1.50 experience rating modification pending receipt of the data. All those without prior Oregon experience will be assigned a 1.00 experience rating modification;

(e) The type, retention, and limitation levels of excess workers' compensation insurance the employer is planning to obtain as required by OAR 436-050-0170;

(f) If applicable, a service agreement between the employer and service company that has been signed by both parties that meets the requirements of OAR 436-050-0210. The agreement must:

(A) Be submitted at least 14 days before the desired date of certification, and be approved by the director before the service company begins processing claims, regardless of the effective date established in the agreement; and

(B) The agreement must also contain the location, mailing address, telephone number, and any other contact information of the service company;

(g) Proof of the employer's ability to provide an acceptable security deposit, including either:

(A) Evidence from a surety bond company admitted to do surety business in this state that they will issue a surety bond for the employer, as Principal, and the Oregon Department of Consumer and Business Services, Workers' Compensation Division, as Obligee; or

(B) Evidence from a qualified bank that they will issue an irrevocable standby letter of credit for the employer with the Oregon Department of Consumer and Business Services as the beneficiary;

(h) Evidence of an occupational safety and health loss control program in accordance with OAR 437-001 as required by ORS 656.430(10); and

(i) Evidence of:

(A) The employer's authorization to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable; or

(B) The employer's status as a municipal or public corporation as defined in ORS 297.405.

(2) Review of application. Within 30 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer that the request for certification as a self-insured employer is approved or denied.

(a) If the request is denied, the notice will include the reason for denial; or

(b) If the request is approved, the notice will include:

(A) Confirmation of the type and the amount of the security deposit required;

(B) Approval of the type, retention, and limitation levels of the excess insurance required; and

(C) Approval of a service agreement submitted under OAR 436-050-0110, if applicable.

(3) Issuance of certification. If approved, the certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder. The effective date of certification will be the first day of the month following the date the certificate is issued, or a later date specified by the applicant.

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

Stat. Auth.: ORS 656.430, 656.726(4)

Stats. Implemented: ORS 656.430

Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0310; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 8-2003(Temp), f. & cert. ef. 7-18-03 thru 1-13-04; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0165

Security Deposit Requirements

(1) Adoption of standards.

The director adopts, by reference, the International Standby Practices 1998 (ISP98), ICC Publication No. 590.

(a) This publication may be accessed from the International Chamber of Commerce website: http://iccwbo.org/policy/banking/; and

(b) Copies of this publication are available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301.

(2) Required security deposit. Each self-insured employer is required to provide a security deposit that is acceptable to the director. Under the conditions and requirements of this rule, the director may accept:

(a) An irrevocable standby letter of credit (ISLOC); or

(b) A surety bond.

(3) Irrevocable standby letters of credit. An ISLOC may be approved by the director as all or part of the security deposit. The director may approve the ISLOC under the following conditions:

(a) The ISLOC must be issued by or confirmed by an Oregon chartered bank or a federally chartered bank from which funds will be immediately payable on demand;

(A) Except federally chartered instrumentalities of the United States operating under authority of the Farm Credit Act of 1971 as amended, the bank issuing the ISLOC must, at the time of issuance, have a long-term certificate of deposit rating of:

(i) "Aaa", "Aa", or "A" in the current monthly edition of "Moody's Statistical Handbook" prepared by Moody's Investors Service Inc., New York; or

(ii) "AAA", "AA" or "A" in the current quarterly edition or monthly supplement of "Financial Institutions Ratings" prepared by Standard & Poor's Corporation, New York;

(B) An ISLOC issued by a bank that does not meet the credit rating requirement of paragraph (A) at the time of issuance will only be accepted with a confirming ISLOC issued by an Oregon state chartered bank or federally chartered bank meeting the credit rating requirement of paragraph (A). The confirming ISLOC must state that the confirming bank is primarily obligated to pay on demand the full amount of the ISLOC regardless of reimbursement from the bank whose ISLOC is being confirmed;

(C) If, subsequent to the issuance of the ISLOC, a bank's rating falls below the acceptable rating level as set forth in paragraph (A), the self-insured employer must, within 60 days of the publication of the lower credit rating:

(i) Replace the ISLOC with a new ISLOC issued by an Oregon state chartered bank or with a federally chartered bank with an acceptable credit rating;

(ii) Confirm the ISLOC by an Oregon state chartered bank or a federally chartered bank that has an acceptable credit rating; or

(iii) Replace the ISLOC with a policy of insurance or a surety bond of equal amount that is approved by the director, as substitute security for the ISLOC, if the policy of insurance or surety bond covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC;

(b) The issuing bank must use Form 3640, "Irrevocable Standby Letter of Credit;"

(c) The ISLOC must be issued under the legal name or assumed business name of the self-insured employer as registered with the Oregon Secretary of State;

(d) The ISLOC will be automatically extended, without amendment, for one year from the expiration date, or any subsequent expiration date, unless, at least 60 days before the expiration date, the director is notified in writing by registered mail or overnight delivery, that the bank has elected not to extend the ISLOC for another period;

(e) If the issuing bank or any confirming bank is closed at the time of expiration of the ISLOC for any reason that would prevent delivery of a demand notice during its normal hours of operation, the ISLOC will be automatically extended for a period of 30 days commencing on the next day of operation;

(f) The ISLOC must be able to be called immediately if:

(A) The self-insured employer has defaulted in payment of its workers' compensation liabilities or obligations, or in payments due to the director under ORS chapter 656;

(B) The self-insured employer has filed for bankruptcy;

(C) The self-insured employer has failed to renew the ISLOC or provide acceptable substitute security at least fifteen days before the expiration date of the ISLOC; or

(D) The beneficiary has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer, and that neither has been provided, notwithstanding written notice to the self-insured employer;

(g) The credit must be available by presentation of the beneficiary's draft drawn at sight on the issuing bank, payable within three business days, when accompanied by one of the statements contained in subsection (f), signed by the director or designee;

(h) The ISLOC is not subject to any qualifications or conditions by the issuing bank or confirming bank and is each bank's individual obligation, which is in no way contingent upon reimbursement;

(i) An ISLOC must state that the funds provided by the ISLOC are not construed to be an asset of the self-insured employer and that if legal proceedings are initiated by any party with respect to the payment of any ISLOC, it is agreed that such proceedings must be subject to the jurisdiction of Oregon courts and Oregon law;

(j) Payment of any amount under an ISLOC must be made only by wire transfer in the name of the "Department of Consumer and Business Services In Trust For [the legal name of the certified self-insured employer]" to a department account, with the State Treasurer, at a designated bank;

(k) The ISLOC must conform to and reference the International Standby Practices 1998 (ISP98), ICC Publication No. 590;

(l) All bank charges for the ISLOC must be for the account of the applicant;

(m) Any amendment to the ISLOC must be approved and accepted by the director before the amendment is effective;

(n) Each self-insured employer that submits an acceptable ISLOC as its security deposit must provide a Form 3529, "Memorandum of Understanding," with the ISLOC, affirming the self-insured employer's acceptance of all of the following requirements:

(A) An ISLOC is provided to the director in place of or in addition to a surety bond or other forms of security that may be determined to be acceptable for certification as a self-insured employer or for continuing as a certified self-insured employer;

(B) The self-insured employer understands the ISLOC will be automatically extended without amendment for an additional one year from the expiration date, or any subsequent expiration date, unless, at least 60 days before the expiration date, the director is notified in writing by the bank that the ISLOC will not be renewed;

(C) The ISLOC may be replaced with an ISLOC or surety bond of equal amount or a policy of insurance that is accepted by the director as substitute security for the ISLOC, if the new ISLOC or surety bond or policy of insurance covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC to be replaced;

(D) The self-insured employer affirms that the ISLOC, in the amount required, is being offered with the understanding that the ISLOC can be called immediately, at the director's discretion, if the director receives notice that the ISLOC will not be renewed; if the self-insured employer fails to pay its workers' compensation liabilities, obligations, or payments due to the director under ORS chapter 656; or the self-insured employer files bankruptcy; or the self-insured employer fails to renew or provide acceptable substitute security at least fifteen days before the expiration date of the ISLOC; or the director has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer and that neither has been provided, notwithstanding written notice to the self-insured employer; and

(E) If legal proceedings are initiated by any party with respect to payment of any ISLOC, then it is agreed that the proceedings will be subject to the jurisdiction of Oregon courts and application of Oregon law.

(4) Surety bonds. A surety bond may be accepted by the director as a security deposit or substitute security deposit for an ISLOC, government securities, moneys, or time deposits. A surety bond may be accepted as all or part of the security deposit. The director, in each particular case, will determine if the surety bond submitted is acceptable, if the issuing surety is acceptable, and if its language and format are acceptable. The director may accept the surety bond under the following conditions:

(a) The surety bond must be issued by a surety company authorized to transact surety business in Oregon;

(b) Form 824, "Surety Bond" must be used for all surety bonds;

(c) The surety bond must be issued under the legal name or assumed business name of the self-insured employer as registered with the Oregon Secretary of State;

(d) Surety bonds submitted for the self-insured employer's security deposit must be continuous in form;

(e) Surety bonds may be terminated by the surety company by giving the director and the Principal written notice stating that on a date not less than thirty days after the date the notice is received by the director, such termination will be effective. Such termination in no way limits the liability of the Surety for subsequent defaults of the Principal's liability or obligations incurred under ORS chapter 656 before the effective date of such termination;

(f) Form 1810, "Surety Bond Rider" must be used for all department required increases or authorized decreases in the penal sum of the surety bond. The surety bond rider is not effective until it is accepted by the department;

(g) Surety bonds and all riders to the surety bonds must be executed by the surety company's attorney in fact and the attorney in fact's appointment and power of attorney must accompany all surety bonds and riders submitted. The power of attorney must authorize the attorney in fact to execute the surety bond in the amount of the penal sum of the bond;

(h) The liability of a surety company under its surety bond may only be discharged in the event that:

(A) The Principal files acceptable substitute security as the security deposit that is accepted by the director as substitute security for the surety bond to be released, covering all past, present, existing, and potential liability of the Principal under ORS chapter 656 and covering all the Surety's liability under the surety bond to be released, in an amount required by the director; and

(B) The surety bond is released as documented in writing from the director or the administrator of the Workers' Compensation Division, or their designated authorized representative;

(C) A policy of insurance or an ISLOC of equal amount that is acceptable by the director may be accepted as substitute security for the surety bond if the policy of insurance or ISLOC covers all workers' compensation liabilities and obligations that would have been covered by the surety bond;

(i) The surety company or its parent must have and maintain an acceptable credit rating in accordance with the following:

(A) Standard and Poor's Insurer Financial Strength Rating of A or better rating, or

(B) A.M. Best Company Financial Strength Rating of B+ or better rating;

(j) A surety bond must be replaced by the self-insured employer with an acceptable type of security deposit within 30 days after notice from the department that the Surety has been placed in conservatorship, is seized, or declares insolvency, or the current credit rating is below the ratings required in subsection (i).

(5) Government securities, certificates of deposit, or time deposit accounts Government securities, certificates of deposit, or time deposit accounts will not be accepted as security deposits for certified self-insured employers who must increase their security deposit or for employers whose self-insurance certification was granted after January 1, 2004.

(a) Government securities, certificates of deposit, or time deposit accounts that were accepted by the director as a self-insured employer's or a self-insured employer group's required security deposit before January 1, 2004, may remain as the security deposit until the maturity date of those investments. At that time, the government securities, certificates of deposit, or time deposit accounts pledged to the department as security deposits must be replaced by a surety bond or ISLOC acceptable to the director.

(b) A self-insured employer that has government securities, certificates of deposit, or time deposit accounts as all or part of its security deposit must complete Form 4023, "Security Agreement and Notice to Intermediary," granting the department a security interest in and control over those financial assets.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.430, 656.726(4)

Stats. Implemented: ORS 656.430

Hist.: WCD 8-2003(Temp), f. & cert. ef. 7-18-03 thru 1-13-04; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0170

Excess Insurance Requirements

(1) Excess insurance requirements. A self-insured employer must have excess workers' compensation insurance coverage appropriate for the employer's potential liability under ORS chapter 656 with an insurer authorized to do business in this state, subject to the following:

(a) Except for endorsements requiring pre-approval by the director under sections (3) and (4) of this rule, the policy providing such coverage and any subsequent endorsements must be filed with the director within 30 days after the effective date of the policy or endorsement;

(b) A self-insured public utility with assets in excess of $500 million as reflected by the employer's audited financial statement submitted in accordance with OAR 436-050-0160 or 436-050-0175, may obtain the required excess workers' compensation insurance coverage from an eligible surplus lines insurer;

(c) The excess insurance policy must include a provision for reimbursement to the director of all expenses paid by the director on behalf of the self-insured employer under ORS 656.614 and 656.443 as if the director were the insured employer, subject to the policy limitations or amounts and limits of liability to the insured employer;

(d) Coverage must be continuous and remain in effect from the date of certification until the certification is revoked or canceled;

(A) Coverage must be specific on a per-occurrence basis;

(B) Coverage may include aggregate excess insurance; and

(C) Coverage may include a deductible endorsement acceptable to the director under sections (3) and (4) of this rule;

(e) Excess insurance obtained under this rule does not relieve any self-insured employer from full responsibility for claims processing and the payment of compensation required under ORS chapter 656 and OAR chapter 436. A self-insured employer may not transfer claims to any excess insurer or service company acting on behalf of an excess insurer for the pro-

cessing of the employer's claims, regardless of the types and amounts of excess coverage; and

(f) When an excess insurance policy is canceled by the excess insurer or the employer, a copy of the notice of cancellation must be filed with the director at least 30 days before the effective date of cancellation.

(2) Self-insured retention level for a self-insured employer group. The self-insured retention level for a self-insured employer group's excess insurance policy must not be less than $300,000.

(3) Changes in the self-insured retention level. Changes in the self-insured retention level and policy limits of the excess insurance require prior approval of the director. Proposed changes must be submitted to the director for approval at least 30 days before the effective date of the change. The director may require a reduction in the self-insured retention level or an increase in the policy limits by order. When determining and approving the retention and limitation levels of the excess insurance, the director will consider:

(a) The employer's financial status;

(b) The employer's financial strength as determined under OAR 436-050-0150 or OAR 436-050-0260;

(c) The employer's risk and exposure;

(d) The employer's claim history; and

(e) The amount of the employer's required security deposit.

(4) Per-accident deductible endorsements. Any endorsements addressing a per-accident deductible in excess of a self-insured employer group's retention level must be approved by the director before the effective date of the endorsement, subject to the following:

(a) In determining whether to approve a deductible endorsement, the director will consider the group's retention level, policy limits, and the items listed in section (3) of this rule; and

(b) The director will not approve per-accident deductible endorsements in excess of the retention level that contain language allowing the excess insurer, at its discretion, to limit its obligations under subsection (1)(c) of this rule.

(5) Director's orders to amend excess insurance. A self-insured employer must comply with an order of the director to reduce the self-insured retention level or increase the policy limitation or amounts and limits of liability of the excess insurance within 30 days after the order's mailing date.

(6) Revocation for failure to comply with these rules. If a self-insured employer does not comply with the requirements of this rule the director may assess civil penalties against the employer, revoke the employer's self-insurance certification, or both. If the director intends to revoke the employer's self insurance certification under this rule:

(a) The employer will be given written notice;

(b) The revocation will be effective 30 days from the employer's receipt of the notice; and

(c) If the employer complies with the requirements of this rule before the effective date of the revocation, the revocation will be canceled and certification will remain in effect.

Stat. Auth.: ORS 656.430, 656.726(4)
Stats. Implemented: ORS 656.430
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0315; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0175
Annual Reporting Requirements

(1) Annual Financial Report. Every self-insured employer must file an annual financial report with the director, subject to the following:

(a) The report must include the employer's audited financial statements or annual report with audited financial statement for the just completed fiscal year, and SEC Form 10K, if issued;

(b) The report must be filed within the following time frames:

(A) A self-insured employer that is not a municipal or public corporation as defined in ORS 297.405 must make the filing within 120 days of the end of its fiscal year; or

(B) A self-insured employer that is a municipal or public corporation as defined in ORS 297.405 must make the filing within 180 days of the end of its fiscal year;

(c) If audited financial statements are not available for filing within the time frames of subsection (b), the self-insured employer may file a financial statement that is certified by the self-insured employer that the financial statement is true and accurate and presents the self-insured employer's financial condition and results of operations as of the date of the statement. The director may require a self-insured employer to submit an audited financial statement if the certified financial statement submitted is insufficient to evaluate the self-insured employer's financial status;

(d) The financial statements and reports must include information sufficient to determine the self-insured employer's financial viability under OAR 436-050-0150 or OAR 436-050-0260; and

(e) All financial statements and annual financial reports filed under this section will be retained by the director for a period of at least three years.

(2) Additional requirements for self-insured employer groups. In addition to the requirements of section (1) of this rule, by March 1 of each year each self-insured employer group must file with the director:

(a) A statement certifying the group meets or exceeds the combined net worth requirement under OAR 436-050-0260(3)(a), as of the date of the statement;

(b) A copy of the fidelity bond furnished to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities. If the group previously filed a copy of a fidelity bond or policy that covers more than one year, and that fidelity bond or policy is still in effect, the group may include a statement in their annual report referring the director to the copy on file in place of providing an additional copy; and

(c) If the self-insured employer group consists of private employer members:

(A) A statement certifying that each member of the group meets the individual net worth requirement under OAR 436-050-0260(3)(b), as of the member's most recent fiscal year end; and

(B) A list of the group's current board members and their professional affiliations.

(3) Claims loss data reporting. The self-insured employer must report claim loss data by March 1 of each year for the purposes of experience rating modification, retrospective rating calculations, and determining deposits. Bulletin 209 provides guidelines for self-insured employers and their authorized representatives to use in submitting the required data. The report must be certified to be true and accurate by an authorized representative of the self-insured employer, and must include:

(a) A report of losses for each year in the experience rating period. The report must cover all claims incurred during the reporting period and must be valued as of January 1 of the current year, and must include:

(A) Contract medical expenses;

(B) Total maximum medical reimbursement amount;

(C) The number of claims for which the maximum medical reimbursement amount is claimed; and

(D) Separate lists including all claims with total incurred losses above and below the National Council on Compensation Insurance split point published in Bulletin 209. The lists must include:

(i) The worker's name, listed in alphabetical order;

(ii) The date of injury;

(iii) The claim number;

(iv) The total amount paid;

(v) Outstanding reserves; and

(vi) Total incurred losses;

(b) A report of losses covering the self-insured employer's non-experience period. The report must list all open claims and must be valued as of January 1 of the current year, and must include:

(A) The worker's name, listed in alphabetical order;

(B) The date of injury;

(C) The claim number;

(D) The total amount paid;

(E) Outstanding reserves; and

(F) Total incurred losses;

(c) Identification of claims involving:

(A) Catastrophes;

(B) The Workers with Disabilities Program;

(C) Permanent total disability;

(D) Fatal benefits;

(E) Third party recoveries; and

(F) Total incurred losses that exceed, or are expected to exceed, the self-insured retention level of the self-insured employer's excess insurance policy;

(d) If the self-insured employer is a self-insured city, county, or qualified self-insured employer group that is exempted from the security deposit requirements under ORS 656.407(3) and OAR 436-050-0185:

(A) The procedures, methods, and criteria used in the process of determining the amount of their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported; and

(B) Upon the director's request, an actuarial study that demonstrates its loss reserve account is actuarially sound and adequately funded under OAR 436-050-0185(2)(a)(D).

(4) Director's requests for additional information. The director may require a self-insured employer to provide additional information, or submit financial statements, reports, or claims loss data more frequently.

(a) The director may require additional information or financial statements for reasons including, but not limited to:

(A) Changes in the financial status or viability of a self-insured employer or group; and

(B) Changes in the net worth, group membership, or private employer group's board membership of a self-insured employer group.

(b) The director may require a self-insured employer to submit additional claim loss data if the nature of the self-insured employer's business has changed since the last annual loss report for reasons including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, or incurred claims costs.

(5) Sanctions for failure to comply with this rule. If a self-insured employer does not comply with the requirements of this rule, the director may:

(a) Require the self-insured employer to increase its deposit and premium assessments by 25 percent;

(b) Conduct an audit to obtain the necessary loss information at the self-insured employer's expense;

(c) Assess civil penalties of up to $250 per day that the information is not provided beyond the deadline; or

(d) Revoke the employer's certification for self-insurance under OAR 436-050-0200 or OAR 436-050-0340.

(6) Claims reserve audits. To ensure each self-insured employer's claims are valued appropriately for use in deposit, experience rating, and retrospective rating calculations, the director will perform routine claims reserve audits.

(a) The values determined at audit will be used to calculate the self-insured employer's security deposit, experience rating factor, and retrospective rating adjustment.

(b) If there is a 10 percent or greater difference between the values determined by the director at audit and the values that were reported by the self-insured employer, the director may assess civil penalties against the employer.

Stat. Auth: ORS 656.407, 656.430, 656.726(4)

Stats. Implemented: ORS 656.407 & 656.430

Hist.: WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 7-1991(Temp), f. 10-4-91, cert. ef. 10-7-91; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 9-2012, f. 12-7-12, cert. ef. 1-1-13; WCD 8-2013, f. 11-12-13, cert. ef. 1-1-14; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 13-2014, f. 11-26-14, cert. ef. 1-1-15; WCD 10-2015, f. 12-24-15, cert. ef. 1-1-16; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0180

Determination of Amount of Self-Insured Employer's Deposit; Effective Date of Order to Increase Deposit

(1) Indicated security deposit. Except for self-insured cities, counties, or qualified self-insured employer groups who are exempted under ORS 656.407(3) and OAR 436-050-0185, each self-insured employer is required to maintain a security deposit with the director in an amount determined by the director, subject to the following:

(a) The deposit will not be less than the greater of:

(A) $100,000;

(B) Future claim liability, including losses incurred but not reported (IBNR), a claims processing administrative cost, and the anticipated assessments payable to the director for the employer's next fiscal year; or

(C) The annual incurred losses for the self-insured employer's last fiscal year, including IBNR, a claims processing administrative cost, and anticipated assessments payable to the director for the employer's next fiscal year;

(b) If the employer is applying for self-insurance, the amount of the initial deposit must not be less than the greater of:

(A) The anticipated assessments payable to the director for the employer's next fiscal year, plus an amount equal to 65 percent of the annual premium the employer would pay if carrier-insured using the applicable occupational base rate premium, as such rate is applied to the anticipated payroll of the employer's Oregon operations for the employer's next fiscal year;

(B) $300,000 plus $30,000 additional for each $100,000 the employer's net worth is below $2 million; or

(C) The amount of the approved self-insured retention level for the employer's excess workers' compensation insurance;

(c) Assessments payable to the director referred to in this section include moneys and assessments due under ORS 656.506, 656.612, and 656.614;

(d) Claims processing administrative costs will be determined by developing a percentage rate to be applied against the employer's unpaid losses;

(A) The rate will be based on the information contained in Schedule P, Part ID of the Annual Statement for the previous calendar year as reported to the Insurance Commissioner by SAIF Corporation and the 20 private insurers who had the highest earned premium reported for the preceding calendar year; and

(B) The rate will be computed annually to be effective for the subsequent fiscal year. The rate will be 105 percent of the median of ratios determined as follows for each of these insurers:

(i) "Loss expenses unpaid" for losses incurred in the latest eight years, divided by

(ii) "Losses unpaid" for losses incurred in the latest eight years; and

(e) Under this section, "Incurred but not reported" (IBNR) will be calculated by applying a loss development factor determined by the director against the employer's annual paid losses.

(2) Financial strength adjustment. If the self-insured employer received a financial strength rating equal to "moderate" under OAR 436-050-0150(5) or OAR 436-050-0260(12), the amount of the deposit determined under section (1) will be increased by the following percentage factors:

(a) 12 total combined points = no change in calculated deposit;

(b) 11 total combined points = no change in calculated deposit;

(c) 10 total combined points = 5%;

(d) 9 total combined points = 10%;

(e) 8 total combined points = 15%; or

(f) 7 total combined points = 20%.

(3) Certified actuarial study. An employer may request for its security deposit amount to be determined based on a recommended loss reserve level established by a certified actuarial study in place of the calculations under sections (1) and (2) of this rule. The director may base an employer's security deposit amount on a certified actuarial study under the following conditions:

(a) The actuarial study must be certified by an actuary who is a member in good standing of the American Academy of Actuaries;

(b) The actuarial study must be submitted to the director within seven days after the date of the director's notice establishing the security deposit amount calculated under sections (1) and (2) of this rule;

(c) The actuarial study must include an estimate or range of estimates of future claim liability and state what provisions for adverse claim development are included in these estimates;

(d) The actuarial study must identify the confidence levels associated with the recommended loss reserve level or loss reserve range;

(e) The actuarial study must include a statement of future claim liability, including the employers incurred but not reported (IBNR) losses;

(f) Subject to the minimum requirements of ORS 656.407 and this rule, upon the director's review and acceptance of the study the amount of the employer's security deposit will be based on:

(A) The actuarially sound recommended loss reserve level if a single estimate is provided; or

(B) The 75% confidence level estimate, if an actuarially sound loss reserve range is provided; and

(g) If there is probable cause to believe the recommended loss reserve level or range is not actuarially sound, the director will determine the security deposit under sections (1) and (2) of this rule. Probable cause includes, but is not limited to:

(A) The actuarial study not containing a statement by the actuary that the recommended loss reserve level or range is actuarially sound;

(B) The actuarial study containing a disclaimer regarding the actuary's qualifications or ability to determine the adequacy of the loss reserve level for current or future liabilities; or

(C) The recommended loss reserve level or entire recommended loss reserve range being less than the 75 percent confidence level estimate established in the actuarial study.

(4) Additional factors for security deposit amount. In determining the amount of deposit the director will take the following factors into consideration:

(a) The financial ability of the employer to pay compensation and other payments due;

(b) The employer's probable continuity of operation;

(c) A self-insured employer group's financial viability, as determined by the director under OAR 436-050-0150 or OAR 436-050-0260;

(d) Retention and limitation levels of the employer's excess insurance in relation to the employer's financial status;

(e) Changes in the employer's business including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, incurred claims costs, or material growth in self-insured exposure;

(f) The balance of the Self-Insured Employer Adjustment Reserve or the Self-Insured Employer Group Adjustment Reserve; and

(g) The employer's credit rating issued by a nationally recognized statistical ratings organization;

(5) Time frame for compliance. A self-insured employer must comply with an order of the director to the self-insured employer to increase the amount of its deposit within 30 days of the order. Failure to comply with this rule may result in the assessment of civil penalties, revocation of the employer's certification of self-insurance, or both.

Stat. Auth.: ORS 656.407, 656.726(4)
Stats. Implemented: ORS 656.407
Hist.: WCB 2-1976(Admin)(Temp), f. & ef. 4-12-76; WCB 3-1976(Admin), f. & ef. 6-15-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0320; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0185
Deposit Exemption for Self-Insured Cities and Counties, Qualifications, Application Procedures, Conditions and Requirements, Revocation and Requalification

(1) Requirements to qualify for deposit exemption. A self-insured city, county, or self-insured employer group that is a municipal or public corporation under ORS 297.405, may apply to be exempt from the security deposit requirements of ORS 656.407(2) and OAR 436-050-0150, if it meets the following requirements:

(a) The city, county, or qualified self-insured employer group must be in compliance with ORS 656.407(2) and OAR 436-050-0180 as an independently self-insured employer or self-insured employer group for the three consecutive years immediately before applying for the exemption; and

(b) The city, county, or qualified self-insured employer group must have in effect a workers' compensation loss reserve account that is actuarially sound and that is adequately funded as determined by the annual audit under ORS 297.405 to 297.740 to pay all compensation to injured workers and amounts due the director under ORS chapter 656. The workers' compensation loss reserve account must also be dedicated to and expended only for payment of compensation and amounts due the director by the city or county under ORS chapter 656.

(2) Application for security deposit exemption. To apply for exemption from ORS 656.407(2), the city, county, or qualified self-insured employer group must submit a written application to the director no later than 45 days before the date the exemption is desired to become effective.

(a) The application must include the following supporting documentation for review and approval:

(A) A copy of the city's, county's, or qualified self-insured employer group's most recent annual audit as filed with the Secretary of State under ORS 297.405 to 297.740 that identifies the actuarially sound funded amount in the dedicated workers' compensation loss reserve if not previously filed as required by OAR 436-050-0175(1);

(B) A copy of the city's, county's, or qualified self-insured employer group's current fiscal year's approved budget documents for internal service funds that state the budgeted amount for the funded workers' compensation loss reserve account;

(C) A resolution or ordinance passed by the city's, county's, or qualified self-insured employer group's governing body that establishes an actuarially sound and adequately funded workers' compensation loss reserve account that dedicates the workers' compensation loss reserve account to and limits expenditures to only the payment of compensation and amounts due the director under ORS chapter 656. The resolution must also include the director's first lien and priority rights to the full amount of the workers' compensation loss reserve account required to pay the present discounted value of all present and future claims under ORS chapter 656; and

(D) A statement giving the amount of the current reserves for present and future liabilities, the amount funded in the workers' compensation loss reserve account, and the procedures, methods, and criteria used in the process of determining the amount funded in their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported.

(i) The statement must include the city's, county's, or qualified self-insured employer group's certification that the loss reserve account is actuarially sound and adequately funded if an actuarial study is not available.

(ii) The director may require a city, county, or qualified self-insured employer group to demonstrate its loss reserve account is actuarially sound and adequately funded based on an actuarial study requested under OAR 436-050-0175(3)(d). The actuarial study must include an IBNR estimate and a copy of the study must be provided to the director.

(b) Within 45 days of receipt of all application materials required under this section, the director will review the application and supporting documentation and notify the city, county, or qualified self-insured employer group that the request for exemption is approved or denied.

(A) If denied, the notice will provide the reasons for the denial, any requirements for reconsideration, and the right to administrative review as provided by OAR 436-050-0008.

(B) If approved, the notice will include:

(i) The confirmation of the effective date of exemption;

(ii) Authorization for cancellation of any surety bond or ISLOC held as security under ORS 656.407(2) and OAR 436-050-0180; and

(iii) Procedures for release of any government securities or time deposits held as security under ORS 656.407(2) and OAR 436-050-0180.

(3) Inadequately funded loss reserve accounts. If the director has probable cause to believe the employer's workers' compensation account is inadequately funded, the director may order a city, county, or qualified self-insured employer group to increase the amount of its workers' compensation loss reserve account and to provide documentation of the increase. The city, county, or qualified self-insured employer group must comply within 30 days of the director's order. Probable cause to believe the workers' compensation loss reserve account is not actuarially sound includes, but is not limited to:

(a) The annual audited financial statement under ORS 297.405 to 297.740 not containing a statement by the auditor that the workers' compensation loss reserve account is adequately funded, or containing a disclaimer regarding the auditor's qualifications or ability to determine adequacy of the loss reserve account; or

(b) For qualified self-insured employer groups required by the director to conduct an actuarial study under OAR 436-050-0175(3)(d) and section (2)(a)(D) of this rule, the actuarial study not containing a statement by the actuary that the loss reserve account is actuarially sound, or containing a disclaimer regarding the actuary's qualifications or ability to determine the adequacy of the reserves for current or future liabilities.

(4) Cancellation of self-insurance certification or loss reserve. A city, county, or qualified self-insured employer group that has been exempted from ORS 656.407(2) and desires to cancel its self-insurance certification or elects to discontinue maintaining an actuarially sound and adequately funded workers' compensation loss reserve account must:

(a) Submit a written request to the director at least 60 days before:

(A) The desired cancellation date of the self-insured certification; or

(B) The effective date of discontinuation of the qualifying workers' compensation loss reserve account;

(b) If the city, county or qualified self-insured employer group desires to cancel its self-insurance certification:

(A) The request under section (a) must comply with OAR 436-050-0200; and

(B) Before the effective date of cancellation the city, county, or qualified self-insured employer group must provide a security deposit, as required by the director, in an amount determined under OAR 436-050-0180 and ORS 656.443; and

(c) If the city, county, or qualified self-insured employer group elects to discontinue maintaining an actuarially sound and adequately funded workers' compensation loss reserve account:

(A) Before the effective date of discontinuation of the qualifying workers' compensation loss reserve account, the city, county, or qualified self-insured employer group must provide a security deposit as required by the director under ORS 656.407(2) and OAR 436-050-0180; and

(B) Failure to provide the required security deposit as required under paragraph (A) will result in revocation of the city's, county's, or qualified self-insured employer group's self-insurance certification as of that date.

Stat. Auth.: ORS 656.407, 656.726(4)
Stats. Implemented: ORS 656.407

Hist.: WCD 7-1991(Temp), f. 10-4-91, cert. ef. 10-7-91; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 8-2013, f. 11-12-13, cert. ef. 1-1-14; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0190
Using Self-Insured Employers Security Deposit/Self-Insured Employers Adjustment Reserve/Self-Insured Employer Group Adjustment Reserve

(1) Default, decertification, or cancellation of self-insurance certification. In the event a self-insured employer defaults, or is unable to make all payments due under ORS chapter 656:

(a) The director will, on behalf of the self-insured employer, assure continued payments in accordance with ORS 656.407, 656.443, and 656.614 and in such a manner as to ensure minimum delay in the processing of injured workers' claims.

(b) The director may refer the self-insured employer's claims for processing to an assigned claims agent selected under ORS 656.054, or designate the service company responsible for continuing to process the employer's claims, subject to the following:

(A) If an individual self-insured employer is being serviced by one or more service companies, the director will designate the service companies to continue processing claims in accordance with the contracts in effect. At least 90 days before the date the contract expires, the service company may submit a proposal to continue processing the claims. The director will consider the proposal along with other options and inform the service company of its decision; and

(B) If a self-insured employer defaults and is self-administering, the director may negotiate to have the employer's claims processed on the employer's behalf.

(c) If a self-insured employer group consisting of private employer members defaults, cancels its self-insurance certification, or is decertified by the director under ORS 656.434, the director may order private employer members of the group to pay an assessment for the group's continuing claim liabilities, under ORS 656.430(7)(a)(D)(i). Failure of the group's members to pay director-ordered assessments under this rule will subject members to civil penalties under ORS 656.745.

(2) Changes in liability or financial viability. In the event a self-insured employer reorganizes its business, assumes additional liability, acquires new operations, buys an additional business, merges with another business, files bankruptcy, emerges from bankruptcy, or otherwise changes its operation in any manner that affects its workers' compensation claims liability, or financial viability as determined under OAR 436-050-0150 or OAR 436-050-0260, the self-insured employer must notify the director of the modification of business within 30 days of the event. Failure to comply with this rule may result in the assessment of civil penalties, revocation of the self-insured employer's certification, or both.

Stat. Auth.: ORS 656.407, 656.434, 656.726(4)
Stats. Implemented: ORS 656.407, 656.443, 656.614
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0322; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0195
Requirements for Changes in Self-Insured Employer Entity

(1) Notification of changes in entity, contact information, or ownership. If there is any change in the entity, changes in addresses, telephone numbers, and points of contact, or ownership of a self-insured employer, the self-insured employer must notify the director in writing within 30 days after the change occurs.

(2) Adding or deleting entities. If a self-insured employer wishes to add or delete entities to a self-insured employer's certification:

(a) The self-insured employer must submit a completed Form 1869, "Endorsement to Include Legal Entity in Self-Insured Certification," signed by an officer of the self-insured employer;

(b) Each entity must enter into an agreement, signed by an officer of the entity, making the entity jointly and severally liable for the payment of any compensation and moneys due to the director by the certified self-insured employer or any other entity included in the self-insured employer's certification; and

(c) The director will determine, based on the information provided, the effect of the change on the deposit required and whether the entities can be combined for experience rating purposes.

(3) Failure to provide notification. Failure to provide notification as required under this rule may result in assessment of penalties, revocation of self-insurance certification, or both.

Stat. Auth.: ORS 656.407, 656.430, 656.726(3)
Stats. Implemented: ORS 656.407 & 656.430
Hist.: WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0200
Self-Insured Certification Cancellation; Revocation

(1) Effective period of self-insurance certification. A self-insured employer's certification remains in effect until:

(a) Revoked as provided by OAR 436-050-0150 to 436-050-0195, ORS 656.434, and 656.440; or

(b) Canceled by the self-insured employer with the approval of the director.

(2) Cancellation of self-insurance certification. If a self-insured employer wishes to cancel its self-insurance certification or cancel the self-insurance coverage of any entity included under its self-insurance certification:

(a) The employer must submit a written request to the director. The request must include:

(A) The arrangements that have been made to process present and future claims for which the employer is responsible;

(B) A statement of all present and future claims liabilities for all liabilities incurred during the period of self-insurance; and

(C) Any reports and moneys due the director under ORS 656.506, 656.612, and 656.614;

(b) The request under subsection (a) must be submitted at least 60 days before the desired date of cancellation. If the request to cancel is submitted fewer than 60 days before the desired date of cancellation, or otherwise does not meet the requirements of this section, the director may set a cancellation date later than the date requested;

(c) If the self-insured employer will continue to have subject workers after the cancellation date the employer must provide the director, before the desired date of cancellation, one of the following:

(A) An insurer filed proof of coverage for a workers' compensation insurance policy under ORS 656.017 and 656.419;

(B) Evidence of a worker leasing arrangement as allowed under ORS 656.850; or

(C) An assigned risk binder that demonstrates compliance with ORS 656.052; and

(d) If the self-insured employer fails to provide the director evidence of coverage under subsection (c) before the desired date of cancellation, the self-insurance certification, including reports and moneys due the director under ORS 656.506, 656.612, and 656.614, will remain in effect.

(3) Responsibility for processing claims. If a workers' compensation insurance policy is in effect and an active self insurance certification is on file with the director for the same employer for the same time period, the self- insured employer has the responsibility of processing claims occurring during the time period as provided under the self insurance certification.

(4) Revocation of self-insurance certification. The director may revoke the self-insurance certification of any self-insured employer that fails to comply with ORS 656.407, 656.430 and these rules; defaults under ORS 656.443; or commits any violation for which a civil penalty could be assessed under ORS 656.745. Except as provided in ORS 656.430(9), notice of certificate revocation will be issued in accordance with the provisions of ORS 656.440.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.434 & 656.440
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0325; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0205
Notice of Self-Insurer's Personal Elections

When a person makes an election under ORS 656.039, 656.128, or 656.140, the self-insured must notify the director in writing of the election and of any cancellation of the election within 30 days of the effective date.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.039, 656.128 & 656.140
Hist.: WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0210

Notice of Self-Insurer's Place of Business in State; Records Self-Insured Must Keep in Oregon

(1) Claims processing location. Every self-insured employer is subject to the following:

(a) The self-insured employer may not process and maintain records of claims subject to ORS chapter 656 at any location outside of this state;

(A) The self-insured employer may receive claims reports at locations outside of the state as long as claims are forwarded to an Oregon location for processing; and

(B) The act of making payment may be done from outside of the state as directed from the Oregon place of business;

(b) The self-insured employer may not have more than three locations at any time where its claims are processed or its claims records are maintained. The self-insured employer must count each physical location where its claims are processed or its records maintained as one location;

(c) The self-insured employer must give the director notice of the location, mailing address, telephone number, email address, and any other contact information requested by the director, of any location in this state where the self-insured employer processes claims and keeps written records of claims upon application for certification;

(A) The information provided to the director in the notice must reasonably lead an inquirer to:

(i) A person who can respond to inquiries as to workers' compensation coverage, claim filing, and claims processing location information; and

(ii) An Oregon certified claims examiner who can respond to reasonable claims processing inquiries within 48 hours, not including weekends or legal holidays;

(B) The notice must include:

(i) Contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director; and

(ii) A company email address that is monitored on a regular basis, where the director can direct general inquiries.

(2) Service companies. A self-insured employer may use one or more service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state under the following conditions:

(a) To change or add service companies, the self-insured employer must file with the director a copy of the agreement entered into between the self-insured employer and each service company, and must give the director notice of the location, mailing address, telephone number, and any other contact information of each service company;

(b) The director must approve the agreement between the self-insured employer and each service company before the service company begins processing the self-insured employers claims, regardless of the processing effective date established in the agreement;

(c) To be approved, the service agreement must:

(A) Be between the self-insured employer and a service company that is incorporated in or authorized to do business in Oregon, and must not be between any other third parties; and

(B) Identify the self-insured employer by company name and specify the self-insured employer's legal or assumed business name as registered with the Oregon Secretary of State;

(C) Identify the service company by name;

(D) Grant the service company a power of attorney to act for the self-insured employer in workers' compensation coverage and claims proceedings under ORS chapter 656; and

(E) Contain only those provisions for workers' compensation activities that are allowed in Oregon. The director may approve an agreement that contains provisions for activities not allowed in Oregon if the agreement or an addendum provides that any services or provisions not allowed under Oregon workers' compensation law will not be applied when processing Oregon claims. The director may require existing agreements that contain provisions for activities not allowed in Oregon to be amended accordingly; and

(d) The self-insured employer must count each service company that processes the self-insured employer's claims as one of the eight claims processing locations allowed under subsection (1)(b) of this rule. Each service company at a physical location must be counted as a separate claims processing location.

(3) Changes in contact information. If a self-insured employer or its service company will change its primary place of business or contact information, the self-insured employer must notify the director of the new location, mailing address, telephone number, email address and any other contact information at least 30 days before the effective date of the change.

(4) Change in claims processing locations. If a self-insured employer changes claims processing locations, service companies, or self-administration:

(a) At least 10 days before the change is effective, the employer must provide notice of the change, including the name of a contact person, telephone number, email address and mailing address of the new claim processor to:

(A) Any worker, or the estate of any deceased worker, who has an open or active claim that will be processed at the new location;

(B) Each worker's attorney, if any;

(C) Each worker's attending physician; and

(D) Any beneficiaries receiving benefits under the claims;

(b) At least 10 days before the change is effective, the employer must provide notice to the director of which claims will be transferred. The notice to the director must include:

(A) A contact person, telephone number, email address, and mailing address for both the sending processor and receiving processor of the claims;

(B) The physical address where the claims will be processed;

(C) Verification of whether the claims to be transferred include closed claims;

(D) If only a portion of the self-insured employer's claims will be transferred, a listing of the claims being transferred that identifies:

(i) The claimant's name;

(ii) The date of injury; and

(iii) The sending processor's claim number; and

(E) Any other information requested by the director; and

(c) If the self-insured employer does not provide notice as required by this section, the director may assess civil penalties against the employer.

(5) In-state activities. For the purpose of this rule, those activities conducted at designated in-state locations and by the authorized representatives of the self-insured employer must include, but are not limited to:

(a) Processing claims for compensation;

(b) Responding to specific claims processing inquiries;

(c) Keeping records required by OAR 436-050-0220;

(d) Accommodating periodic in-state audits by the director; and

(e) Any other activity necessary to meet the requirements of ORS chapter 656 and OAR chapter 436.

(6) Additional processing locations. Notwithstanding section (1) of this rule, the director may approve up to two additional claims processing locations, under the following conditions:

(a) The self-insured employer must demonstrate:

(A) That meeting the requirements of section (1) of this rule will impose a financial or operational hardship on the employer;

(B) That such additional locations will result in improved claims processing performance of the employer; and

(C) That the auditing functions of the director can be met without unnecessary expense to the director; and

(b) If, upon audit, a self-insured employer's claims processing performance has not remained at the levels as described in OAR 436-060, the approval for additional locations will be withdrawn.

(7) Payment location. Notwithstanding section (1) of this rule, a self-insured employer may, with the prior approval of the director, make compensation payments from a single location other than the designated claims processing location. Approval of such a location may be revoked if at any time:

(a) Timeliness of compensation payment falls below the minimum standards as established in OAR 436-060;

(b) Written record of compensation payments is not available; or

(c) There is not sufficient written documentation to support the issuance of a check for compensation.

(8) Maintenance of payroll records. Notwithstanding section (1) of this rule, a self-insured employer may, with prior approval of the director, have one additional location, in or out of state, for maintaining payroll records pertaining to premium assessments and assessment/contributions.

Stat. Auth.: ORS 656.455, 656.726(4)

Stats. Implemented: ORS 656.455

Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0330; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0220

Records Self-Insured Employer Must Keep in Oregon; Period to be Retained, Removal and Disposition

(1) Claims records self-insured employers must keep in Oregon. Each self-insured employer is required to keep the following records in this state, and make those records available to the director upon request:

(a) Written records necessary to ensure compliance with ORS 656.506, 656.612, 656.614, and 656.622 including:

(A) A record of payroll by National Council on Compensation Insurance classification; and

(B) Complete records of all assessments, employer and employee contributions, and all such money due the director;

(b) Written records relating to its safety and health program as required by ORS 656.430(10) and OAR 437-001;

(c) Written records used and relied upon in processing claims;

(d) A written record of all payments made as a result of any claim, including documentation of:

(A) The amount of the payment;

(B) The date the payment was issued;

(C) The date payment was mailed or delivered; and

(D) An explanation of the time period between the date the payment was issued and the date the payment was mailed or delivered, if any;

(e) A written record of all reimbursements and recoveries received on each claim;

(f) A written record of the approval or denial of claims for supplemental temporary disability benefits under ORS 656.210(5)

(g) A summary sheet for each claim showing all payments made, separated into disability, medical, and vocational assistance payments showing all reimbursements made and cumulative totals.

(A) The record of disability payments should be limited to statutory benefits and not include any additional employer obligations.

(B) Expenses must not be included in any of the three columns required on the summary sheet. "Expenses" are defined in National Council on Compensation Insurance, Workers' Compensation Statistical Plan, Part IV(available from NCCI, www.ncci.com, 800-622-4123); and

(h) Written records, or copies of records, of claims processed by prior service companies.

(2) Removal of claim records. A self-insured employer may remove the following records, under the conditions described in this section:

(a) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial is final by operation of law.

(b) Records of any claim for a compensable injury, including a denied claim that is found to be compensable, may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(c) If administrative or judicial review is requested, the claim records may not be removed from this state or disposed of until the review is concluded and the time for an appeal from such review has expired, or at least one year after final payment of compensation has been made, whichever is the last to occur.

(3) Destruction of claims records. The self-insured employer may destroy claim records when the self-insured employer can verify that all potential for benefits to the injured worker or the worker's beneficiaries is gone.

(4) Retention of payroll records required under this rule. Payroll records retained under section (1)(a) of this rule may be removed from the state or destroyed at the end of three full calendar years after the calendar year in which the money was remitted.

Stat. Auth.: ORS 656.455, 656.726(4)

Stats. Implemented: ORS 656.455

Hist.: WCD 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0335; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0230

Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation

(1) Permission to keep records and process claims outside of Oregon. Notwithstanding OAR 436-050-0220, with the prior approval of the director a self-insured employer may keep claims records and process claims at a location outside this state, under the following conditions:

(a) The self-insured employer must submit a written application to the director;

(A) The application must contain the reasons for the request and the mailing address, telephone number, email address and any other contact information of the location where the records will be kept and the claims processed; and

(B) The application must provide the director contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director, and a company email address that is monitored on a regular basis;

(b) Upon receipt, the director will review the application and notify the employer if the request has been approved or denied. If the request has been denied, the director will notify the employer of the reasons for the denial; and

(c) The director will not grant permission to any self-insured employer that has committed acts or engaged in a course of conduct that would be grounds for revocation of permission or that are contrary to any of the provisions of this rule.

(2) Requirements. A self-insured employer that keeps claims records and processes claims at a location outside this state must:

(a) Process claims and make payment of compensation in an accurate and timely manner;

(b) Make reports to the director promptly as required by ORS chapter 656 and the director's administrative rules;

(c) Pay to the director promptly all assessments and other money as it becomes due;

(d) Increase or decrease its security deposit promptly when directed to do so by the director under ORS 656.407(2);

(e) Comply with the rules and orders of the director in processing and paying claims for compensation; and

(f) Provide written records which have been removed from this state to the director as requested within a reasonable time not to exceed 14 days or as otherwise negotiated.

(3) Revocation of permission. After notice given as required by ORS 656.455(2), permission granted under this rule will be revoked by the director if the employer has committed acts or engaged in a course of conduct that are in violation of any provisions of this rule.

Stat. Auth.: ORS 656.455, 656.726(4)

Stats. Implemented: ORS 656.455

Hist.: WCD 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0340; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0260

Qualifications of a Self-Insured Employer Group

The director may certify five or more employers as a self-insured employer group if the employers, as a group, meet all the requirements of this rule.

(1) Organization The employers must be organized as a corporation or cooperative under ORS chapter 60, 62, or 65. If the group is a governmental subdivision, it must have formed a governmental entity as provided under ORS 190.003 to 190.110.

(2) Designation of responsible parties. The employers must designate:

(a) A board of trustees; and

(b) An administrator, subject to section (9) of this rule.

(3) Group net worth requirements. The employers must demonstrate and maintain:

(a) That the combined total of the individual members net worth is at least $3 million; and

(b) For private employer groups, that each individual member's net worth is at least $150,000. Private employer groups must obtain annual financial data from all members regarding their individual fiscal year-end net worth.

(4) Excess insurance. The employers must obtain excess insurance coverage of the type and amounts approved by the director, including a self-insured retention of at least $300,000.

(5) Claims processing staff. The employers must establish proof of an adequate staff qualified to process claims by:

(a) Employing and retaining at each claims processing location, at least one claims examiner that is certified under OAR 436-055-0070 to process claims in this state, and is actually involved in the claims processing function; or

(b) Contracting the services of one or more service companies that employ at each claims processing location in this state, at least one claims examiner that is certified under OAR 436-055-0070 to process claims in this state, and that is actually involved in processing the group's claims.

(6) Changes in group membership. The employers must develop a method approved by the director to notify the director of:

(a) The commencement or termination of membership by employers in the group, and the effect on the remaining combined net worth of the employers in the group; and

(b) If a member who terminates membership in the group will continue to be a subject employer, and if so, what arrangements have been made to continue coverage.

(7) Safety and health loss prevention program. The employers must establish a safety and health loss prevention program as required by OAR 437-001, and demonstrate that accident prevention is likely to improve through self-insurance.

(8) Commons claims fund. If applicable, the employers must create a common claims fund approved by the director under OAR 436-050-0300, or specify that the amount calculated under OAR 436-050-0300(3) or (6) is to be included in the self-insured employer group's security deposit under OAR 436-050-0180.

(9) Designation of administrative entity. The employers must designate an entity for the group responsible for centralized claims processing, payroll records, safety requirements, recording and submitting assessments and contributions and making such other reports as the director may require.

(a) For groups consisting of private employer members, the designated entity may not be a member of the group or the group's board, or a trustee for the group.

(b) With the approval of the director, a self-insured employer group may use service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer group must:

(A) File, with the director, a copy of the agreement entered into between the employer group and each company; and

(B) Give the director notice of the location, mailing address, telephone number, email address, and any other contact information for each service company.

(10) Proof of financial ability. Unless exempt under OAR 436-050-0185, the employers must establish proof of financial ability by:

(a) Providing a security deposit that the director determines is acceptable under OAR 436-050-0165, and in an amount determined under OAR 436-050-0180;

(b) Demonstrating financial viability based on factors including, but not limited to:

(A) The group meeting the combined net worth requirements in subsection (3)(a) of this rule;

(B) For private employers that are members of a self-insured group, meeting the individual net worth requirements in subsection (3)(b) of this rule; and

(c) Demonstrating acceptable financial strength by maintaining a rating equal to "strong" or "moderate" as determined under section (11) and (12) of this rule.

(11) Financial strength analysis. The financial reports submitted by the self-insured employer group under OAR 436-050-0175(1) must contain information sufficient to calculate the financial ratios described in this section. The points awarded for each ratio will be used to determine the self-insured employer group's financial strength under section (12) of this rule.

(a) For the purposes of calculating the financial ratios under this section:

(A) The face value of a self-insured employer's irrevocable standby letter of credit (ISLOC) used to satisfy the director's requirement for a security deposit, may not be included in the self-insured employer group's reported assets;

(B) Current assets include all assets that may be reasonably expected to be converted into cash, or could become the equivalent of cash, within one year in the normal course of business;

(i) Cash must include all readily available and unrestricted funds such as bills, coin, or checking account balances. Cash does not include funds held in special deposit or escrow accounts where some degree of legal constraint against their use exists;

(ii) Current assets include, but are not limited to, cash, accounts receivable, inventory, prepaid expenses, and investments, marketable securities and bonds that mature within one year or may be converted to cash without penalties or fees; and

(iii) Current assets must not include fixed assets, accumulated depreciation, intangible assets, or investments, marketable securities, or bonds with maturity dates of one year or longer;

(C) Current liabilities are debts and obligations expected to be due within the next year;

(i) Examples of such liabilities include accounts payable, notes payable, accrued taxes, and wages and salaries owed to workers; and

(ii) Current liabilities do not include debts or claims on assets that will be due a year or more in the future or long-term liabilities intended to provide more permanent funds for the business, including bank loans and long-term bonds;

(D) Earned contributions are the net revenues from group members' contributions;

(i) Financial statements and reports may otherwise refer to this component as net premium, member contributions, or operating revenue; and

(ii) At the director's discretion, excess insurance premiums may be deducted from earned contributions when there is a reasonable likelihood of performance by the excess insurance carrier; and

(E) Adjusted net worth is the net worth reported in the financial statement of the self-insured employer group less disallowed assets;

(i) Disallowed assets are prepaid expenses, inventory, and accounts receivable over 90 days old; and

(ii) Financial statements and reports may otherwise refer to adjusted net worth as net position, net assets, surplus, owner's equity, or shareholders' equity. The adjusted net worth is the total assets minus the sum of the total liabilities and the disallowed assets.

(b) The current ratio is calculated by dividing current assets by current liabilities. A maximum of six points are possible for the current ratio, to be awarded as follows: [Table not included. See ED. NOTE.]

(c) The cash ratio is calculated by dividing cash by current liabilities. A maximum of six points are possible for the cash ratio, to be awarded as follows: [Table not included. See ED. NOTE.]

(d) The premium-to-surplus ratio is calculated by dividing earned contributions by the group's adjusted net worth. A maximum of six points are possible for the premium-to-surplus ratio, to be awarded as follows: [Table not included. See ED. NOTE.]

(12) Rating of financial strength. The self-insured employer group's financial strength will be rated based on the sum of the points awarded under section (11) of this rule.

(a) A sum of 13 to 18 points is equal to a strong rating:

(A) The director will approve initial or continued self-insured group certification if the group meets all the requirements of this rule; and

(B) The group's security deposit amount will be determined based on OAR 436-050-0180(1) or (3);

(b) A sum of 7 to 12 points is equal to a moderate rating:

(A) The director will approve initial or continued self-insured group certification if the group meets all the requirements of this rule; and

(B) The group's security deposit amount will be determined based on OAR 436-050-0180(1) and (2), or (3); and

(c) A sum of 0 to 6 points is equal to a weak rating:

(A) The director may not approve the application for initial self-insured employer group certification;

(B) For an existing certified self-insured employer group, the director may:

(i) Provide the group notice of the director's intent to revoke its self-insurance certification under OAR 436-050-0340(1); or

(ii) Increase the security deposit calculated in OAR 436-050-0180 by an amount based on factors including, but not limited to, the considerations identified in OAR 436-050-0180(4);

(iii) Allow the amount of the security deposit to be determined based on a certified actuarial study under OAR 436-050-0180(3); or

(iv) Request that the group submit a financial correction plan that demonstrates the group's ability to improve its rating, in a reasonable time period, without hampering the group's ability to pay compensation and other amounts due under ORS chapter 656; or

(C) The director may request additional information or financial reports to verify the employer's financial strength.

(13) Compliance with rules. The employer group must comply with the requirements of ORS chapter 656 and OAR chapter 436.

(14) Claims processing location. The self-insured employer group must maintain at least one place of business in this state where the member's claims will be processed and written records of claims and other records kept as required by OAR 436-050-0210 and 436-050-0220.

(15) Failure to maintain qualifications. The employer group and its members must maintain the qualifications required under this rule.

(a) Failure of a private employer that is a member of a self-insured employer group to maintain individual net worth of at least $150,000 will result in cancellation of that member's participation in the group under OAR 436-050-0290.

(b) Failure of a certified self-insured employer group to maintain the qualifications required in this rule will result in revocation of the self-insured employer group's certification. If the director intends to revoke the self-insured employer group's certification:

(A) The director will give the group 30 days written notice of the intent to revoke the self-insured certification;

(B) The revocation will be effective 30 days from the date the group receives the revocation notice; and

(C) If the self-insured employer group complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

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

Stat. Auth.: ORS 656.407, 656.430, 656.726(4)

Stats. Implemented: ORS 656.407 & 656.430

Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0405; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0270

Applying for Certification as a Self-Insured Employer Group: Private Employers

(1) Employers applying for certification as a self-insured employer group must submit:

(a) A completed Form 1867, "Application to Become a Self-Insured Employer Group: Private Employers;"

(b) Proof in the form of a certificate from the Secretary of State's Corporation Division showing the employer group as a corporation or cooperative;

(c) A copy of the bylaws or corporate minutes that include:

(A) Designation of specific individuals as trustees for the corporation or cooperative;

(B) Naming an administrator to administer the financial affairs of the group who may not be a member of the group or the group's board, or a trustee for the group; and

(C) The criteria used by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(d) A copy of the fidelity bond provided to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities;

(e) The current financial statements of each member making application demonstrating that the members meet the requirements of OAR 436-050-0260;

(f) An individual report by employer showing the employer's payroll by class and description and loss information for the last four calendar years;

(g) A completed Form 1866, "Group Self-Insured Indemnity Agreement," or another form authorized by the director, that jointly and severally binds each member for the payment of any compensation and moneys due to the director by the group or any member of the group. Government subdivisions do not need to submit this agreement;

(h) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(i) Proof of an adequate staff qualified to process claims under OAR 436-050-0260(5);

(j) If applicable, a service agreement between the employer and service company that has been signed by both parties that meets the requirements of OAR 436-050-0210(2). The agreement must:

(A) Be submitted at least 14 days before the desired date of certification, and approved by the director before the service company begins processing claims, regardless of the effective date established in the agreement; and

(B) Contain the location, mailing address, telephone number, and any other contact information of the service company;

(k) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(l) A procedure for notifying the director of:

(A) The commencement or termination of employers within the group and the effect on the remaining combined net worth of the group; and

(B) Arrangements made by an employer leaving the group to continue insurance coverage.

(m) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300, or specification if the amount calculated under OAR 436-050-0300(3) or (6) is to be included in the self-insured employer group's security deposit; and

(n) The type of security deposit the employer group wishes to provide, with appropriate justification.

(2) Audited financial statements. Notwithstanding subsection (1)(e) of this rule, the director may require an audited financial statement before considering an application by a group for self-insurance.

(3) Review of application. Within 60 days of receipt of all information required under this rule, the director will review the application and notify the employer group that the request for certification as a self-insured employer group is approved or denied:

(a) If the request is denied, the employers will be notified of the reasons for denial; or

(b) If the request is approved, the notice will include:

(A) The amount of security deposit required;

(B) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and

(C) Approval of the service agreement submitted under subsection (1)(j) of this rule.

(4) Issuance of certification. If approved, the certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder. The effective date of certification will be the first day of the month following the date the certification is issued, or a later date specified by the applicant.

Stat. Auth.: ORS 656.407, 656.430, 656.726(4)

Stats. Implemented: ORS 656.407 & 656.430

Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0410; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0280

Applying for Certification as a Self-Insured Employer Group: Governmental Subdivisions

(1) Required information. Governmental subdivisions applying for certification as a self-insured employer group must submit:

(a) A completed Form 1867, "Application to Become a Self-Insured Employer Group;"

(b) Proof that the governmental subdivisions have formed an intergovernmental entity as provided under ORS 190.003 to 190.110;

(c) An intergovernmental agreement that includes:

(A) Designation of specific individuals as trustees for the group and naming an administrator to administer the financial affairs of the group; and

(B) The criteria to be used by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(d) A copy of the fidelity bond provided to the group by the administrator or a copy of the comprehensive crime policy obtained by the group, in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities;

(e) The current financial statements of each member making application, demonstrating the members meet the combined net worth requirement under OAR 436-050-0260;

(f) An individual report by employer showing the governmental subdivision's payroll by class and description and loss information for the last four calendar years;

(g) A resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(h) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(i) Proof of an adequate staff qualified to process claims under OAR 436-050-0260(5);

(j) If applicable, a service agreement between the employer and service company that has been signed by both parties that meets the requirements of OAR 436-050-0210(2). The agreement must:

(A) Be submitted at least 14 days before the desired date of certification, and approved by the director before the service company begins pro-

cessing claims, regardless of the effective date established in the agreement; and

(B) Contain the location, mailing address, telephone number, and any other contact information of the service company;

(k) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(l) A procedure for notifying the director of:

(A) The commencement or termination of governmental subdivisions within the group and the effect on the remaining combined net worth of the group; and

(B) Arrangements made by a governmental subdivision leaving the group to continue insurance coverage;

(m) If applicable, A program whereby each employer within the group contributes to a common claims fund under OAR 436-050-0300, or specification that the amount calculated under OAR 436-050-0300(3) or (6) is to be included in the self-insured employer group's security deposit; and

(n) The type and amount of security deposit the group wishes to provide, with appropriate justification. In no case will the security deposit amount be less than $300,000.

(2) Audited or certified financial statements. Notwithstanding subsection (l)(e) of this rule, the director may require an audited or certified financial statement before considering an application by a group for self-insurance.

(3) Review of application. Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the group that the request for certification as a self-insured employer group is approved or denied.

(a) If the request is denied, the notice will include the reasons for denial; or

(b) If the request is approved, the notice will include:

(A) The amount of the security deposit required; and

(B) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and

(C) Approval of the service agreement submitted under subsection (1)(j) of this rule.

(4) Issuance of certification. The certification of self-insurance will be issued upon receipt of the security deposit, and the appropriate excess insurance binder. The effective date of certification will be the date the certification is issued, or a later date specified by the applicant,.

Stat. Auth.: ORS 656.407, 656.430, 656.726(4)
Stats. Implemented: ORS 656.430 & 656.407
Hist.: WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0290

Commencement/Termination of Employers with a Self-Insured Employer Group; Effect on Net Worth; Extension of Coverage; Change in Entity; Change of Address; Recordkeeping

(1) Addition of new members. Prospective new members of a self-insured employer group must submit an application to the board of trustees, or its administrator. The administrator of a group consisting of private employer members may not be a member of the group. The trustees, or administrator, may approve the application for membership under the bylaws of the self-insured employer group. Once approved, the administrator or board of trustees must submit to the director, within 30 days of the effective date of membership, a completed Form 1869, "Endorsement to Self-Insured Group Application" or a form approved by the director, which must be accompanied by:

(a) A current financial statement of the employer applying;

(b) Evidence of at least $150,000 individual net worth if the prospective new member is a private employer;

(c) An agreement signed by the administrator of the self-insured employer group and the employer, making the employer jointly and severally liable for the payment of any compensation and moneys due to the director by the group or any member of the group; or, if a governmental subdivision self-insured employer group, a resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(d) A statement showing the effect on the new combined net worth of the group; and

(e) The employer's payroll by class and description and loss information for the last four fiscal or calendar years.

(2) Incomplete or incorrect submissions. Incomplete submissions or incorrectly completed endorsements to add new members received by the director will not be considered filed, and the employer will not be included in the self-insurance of the self-insured employer group. Failure to file a correct and complete endorsement with the required supporting documentation within 30 days of the effective date of membership may result in the assessment of civil penalties.

(3) Termination of membership. Individual employer members may elect to terminate their membership in a self-insured group or be subject to cancellation by the group under the bylaws of the group. Groups consisting of private employer members must also cancel the membership of any private employer member that fails to maintain the minimum individual net worth required under OAR 436-050-0260(15). Such cancellation must occur within 30 days of the group's receipt of the employer member's most recent fiscal year end financial data demonstrating insufficient net worth. The self-insured employer group must submit the following information to the director no later than 10 days before the effective date of the member's termination or cancellation:

(a) A statement, without disclaimers or qualifying language as to the accuracy of the information provided:

(A) Showing the effect of the employer member's termination or cancellation on the remaining combined net worth of the group; and

(B) Certifying that the group continues to meet the combined net worth requirements in OAR 436-050-0260;

(b) Evidence that the employer member requesting termination or being cancelled has made alternate arrangements for coverage if the employer member continues to employ subject workers;

(c) Evidence that the employer member requesting termination or being cancelled has been provided a written reminder about its potential future liability as described in section (1)(c) of this rule; and

(d) The expected date of cancellation or termination.

(4) Revocation of certification due to change in membership. If the director determines the cancellation or termination of an employer member adversely affects the self-insured employer group to the extent that the group no longer qualifies for self-insurance certification, the director may revoke the self-insured employer group's certification under OAR 436-050-0340(3).

(5) Change in entity. If there is a change in the entity of an employer member, the employer member must reapply for membership within the self-insured employer group under this rule. A change in entity includes, but is not limited to:

(a) A partner joining or leaving a partnership;

(b) A sole proprietorship, partnership, or corporation, changing to another of those ownership structures; or

(c) An employer selling an existing business to another person, except in the case of a corporation.

(6) Change in name or address. An employer member of a group must, within 10 days after there is a change of address or assumed business name, notify the board of trustees or administrator of the change.

(a) A change of address includes, but is not limited to:

(A) Establishment of a new or additional location; or

(B) Termination of an existing location.

(b) The administrator or board of trustees must, within 10 days, submit to the director an endorsement as notice of the change. The endorsement must state specifically which location is being deleted or which is being added and identify if address is the mailing, operating, or the principal place of business of the location.

(7) Maintenance of coverage records. The self-insured employer group is responsible for maintaining coverage records relating to each employer member, to include:

(a) The employer member's application for membership in the self-insured employer group, with original signatures;

(b) The employer member's liability agreement under OAR 436-050-0270(1)(g), or resolution under OAR 436-050-0280(1)(g), with original signatures;

(c) Cancellation or termination notices;

(d) Reinstatement applications and notices; and

(e) Records on the locations of employers that have been canceled or have terminated their participation in the group.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.434, 656.440
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0420; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD

6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0300
Self-Insured Employer Group, Common Claims Fund

(1) Except for qualified self-insured employer groups approved by the director as exempt from security deposit requirements under OAR 436-050-0185, a self-insured employer group must establish, under the direction and control of the board of trustees and administrator, a common claims fund for the sole purpose of ensuring the availability of funds to make certain the prompt payment of all compensation and all other payments that may become due from such self-insured employer group under the workers' compensation law. This requirement does not apply in any year in which the director applies an incurred but not reported (IBNR) factor of greater than zero percent in the determination of the self-insured employer group's security deposit under OAR 436-050-0180.

(2) The common claims fund must be maintained in an account held by an Oregon state chartered or a federally chartered bank. Government subdivisions certified as a self-insured employer group may also maintain the common claims fund in a "Local Government Investment Pool" account held by the Office of the State Treasurer.

(3) Except as provided in section (6) of this rule, the balance of the common claims fund must be maintained in an amount at least equal to 30 percent of the average of the group's paid losses for the previous four years. The full sum of the required common claims fund balance must be maintained at all times.

(4) The director may require the self-insured group to increase the amount maintained in the common claims fund.

(5) By March 1 of each year, a self-insured employer group must provide the director with adequate documentation to validate the balance in the common claims fund or notice that the amount calculated under section (3) or (6) of this rule must be included in the determination of the self-insured employer group's security deposit under OAR 436-050-0180. The director may require a self-insured employer group to provide documentation of the common claims fund balance more frequently.

(6) For governmental subdivisions certified as a self-insured employer group, the balance of the common claims fund must be maintained in an amount at least equal to 60 percent of the average of the group's yearly paid losses for the previous four years.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.430
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0420; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 1-2013(Temp), f. & cert. ef. 1-23-13 thru 7-21-13; WCD 5-2013, f. 7-3-13, cert. ef. 7-22-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0340
Group Self-Insurance Revocation

Notwithstanding ORS 656.440, the certification of a self-insured employer group may be revoked by the director after giving 30 days notice if:

(1) The employer group does not comply with ORS 656.430(7) or (8), 436-050-0170 to 436-050-0190, 436-050-0260, or 436-050- 0290;

(2) There are fewer than five employers within a group;

(3) The net worth of the group falls below that required by OAR 436-050-0260(3);

(4) The employer group defaults in payment of compensation or other payments due the director;

(5) The employer group commits any violation for which a civil penalty could be assessed under ORS 656.745; or

(6) The employer group or any member of the group submits any false or misleading information.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.434 & 656.440
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86, Renumbered from 436-051-0440; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 10-2014, f. 8-15-14, cert. ef. 9-15-14; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0400
Responsibility for Providing Coverage Under a Lease Arrangement

(1) Every worker leasing company providing workers to a client must satisfy the requirements of ORS 656.017, 656.407, or 656.419.

(2) Every worker leasing company providing leased workers to a client must also provide workers' compensation insurance coverage for any subject workers of the client, unless the client has an active workers' compensation insurance policy proof of coverage on file with the director or is certified under ORS 656.430 as a self-insured employer. In the latter circumstance, the client's insurer or the self-insured employer will be deemed to provide insurance coverage for all leased workers and subject workers of the client.

(3) If an insured client allows its workers' compensation insurance policy to cancel or does not obtain a renewal of the policy, or if a self-insured client allows its certification to terminate, and the client continues to employ subject workers or has leased workers, the client will be considered a noncomplying employer unless the worker leasing company has made the filing with the director under OAR 436-050-0410(1).

(4) A client can obtain leased workers from only one worker leasing company at a time unless the client has an active workers' compensation insurance policy proof of coverage on file with the director or is certified under ORS 656.430 as a self-insured employer.

(5) A worker leasing company must not provide workers' compensation coverage for another worker leasing company doing business in Oregon whether or not any of the worker leasing companies involved is licensed for worker leasing in Oregon.

(6) A client employer may not obtain workers by contract and for a fee on a non-temporary basis from an unlicensed worker leasing company.

Stat. Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 15-1994, f. 12-23-94, cert. ef. 2-1-95; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0410
Notice to Director of Lease Arrangement; Termination

(1) Within 14 days after the effective date of the lease arrangement or contract, a worker leasing company must file written notice with the director and its insurer, using Form 2465, "Worker Leasing Notice to the Department of Consumer and Business Services," that it is providing leased workers to a client and workers' compensation coverage. The notice must be correct and complete, and must include:

(a) The client's:
(A) Legal name;
(B) FEIN or other tax reporting number;
(C) Type of ownership;
(D) Primary nature of business;
(E) Mailing address; and
(F) Street address in Oregon;
(b) The worker leasing company's:
(A) Legal name;
(B) Mailing address;
(C) FEIN or other tax reporting number;
(D) WCD worker leasing license number, if any;
(E) Workers' compensation insurer's name (or "self-insured");
(F) Effective date of leasing contract;
(G) Contact name and phone number; and
(H) A signature of a representative of the worker leasing company.

(2) A worker leasing company may terminate its obligation to provide workers' compensation coverage by giving to its insurer, its client, and the director written notice of the termination. A notice of termination must state the effective date and hour of termination, but the termination will be effective not less than 30 days after the notice is received by the director. Notice to the client under this section must be given by mail, addressed to the client at its last-known address.

Stat. Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0420
Temporary Worker Distinguished from Leased Worker

(1) A person who provides a worker to work for a client will be considered to be providing the worker on a "temporary basis" only if there is contemporaneous written documentation that indicates the duration of the work to be performed and that the worker is provided for a client's special situation under ORS 656.850(1)(b). Contemporaneous documentation means documents that are created at the time the temporary service provider and the client employer make the arrangements for placement of the worker. Upon the director's request, the documentation must be provided to the director by either the temporary service provider or the client.

Contemporaneous documentation in support of workers being provided on a temporary basis includes one or more of the following conditions:

(a) To cover employee absences or employee leaves, including but not limited to such things as maternity leave, vacation, jury duty, or illness from which the permanent worker will return to work;

(b) To fill a professional skill shortage, including but not limited to, professionals such as engineers, architects, electricians, plumbers, pharmacists, nurses, or other professions, whether licensed or not, to supplement or satisfy a shortage of that skill for a known duration. Supporting documentation may include license information and whether the worker is supplementing or satisfying a client employer's need for the skill;

(c) To staff a seasonal or sporadic increase in workload, indicated by a temporary increase in demand upon an employer's normal workload that requires additional assistance to meet the demand. When the increased demand ends, the additional positions are eliminated. Documentation must include what constitutes the demand establishing why this special situation is beyond the norm;

(d) To staff a special assignment or project outside of the routine activities of the business where the worker will be terminated or assigned to another temporary project upon completion. For example, a construction contractor may need assistance on a construction site to help clear branches and other debris after a windstorm so the regular construction crew can continue its work. Documentation must describe the project and why it is unusual;

(e) To hire a student worker that will be provided and paid by a school district or community college through a work experience program. Documentation must include the name of the school and the work experience program; or

(f) To cover special situations where the worker has a reasonable expectation of transitioning to permanent employment with the client employer and the client employer uses a pre-established probationary period in its overall employment selection program. Documentation must include copies of the client employer's written program or other evidence supporting the pre-established probationary period and overall employment selection program.

(2) If a person provides workers, by contract and for a fee, to work for a client and any such workers are not provided on a "temporary basis," that person will be considered a worker leasing company.

(3) If a person provides both leased workers and workers on a temporary basis, that person must maintain written records that show specifically which workers are provided on a temporary basis. If the written records do not specify which workers are provided on a temporary basis, all workers are deemed to be leased workers.

Stat. Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 15-1994, f. 12-23-94, cert. ef. 2-1-95; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0440
Qualifications, Applications, and Renewals for License as a Worker-Leasing Company

(1) Each person applying for initial license or renewal as a worker leasing company must:

(a) Be either an Oregon corporation or other legal entity registered with the Oregon Secretary of State, Corporations Division to conduct business in this state;

(b) Maintain workers' compensation coverage under ORS 656.017; and

(c) Upon application approval and before licensure, pay the required licensing fee of $2,050.

(2) Each person applying for initial license or renewal as a worker leasing company must submit a completed Form 2466, "Application for Oregon Worker Leasing License." The form and accompanying documentation must include:

(a) Legal name;

(b) Mailing address;

(c) In-state and out-of-state phone numbers;

(d) FEIN or other tax reporting number;

(e) Type of business;

(f) Physical address for Oregon principal place of business;

(g) Assumed business names;

(h) Name of workers' compensation insurer (or "self-insured") and policy number;

(i) Names and contact information of the representatives at the Oregon locations;

(j) List of controlling persons, and in the case of privately held entities all owners, including their names, titles, residence addresses, telephone numbers, email addresses, and dates of birth;

(k) For a person applying for an initial license, a list of all states where the person operates as a leasing company or professional employer organization (PEO), copies of licenses, registrations, recognitions, or certifications from states that require those actions, and a verifiable statement that the remaining states of operation, if any, do not require licensure, registration, recognition, or certification to provide worker leasing or PEO services;

(l) Verification of compliance with tax laws from Oregon Employment Department, Oregon Department of Revenue, and the Internal Revenue Service, using Attachments A, B, and C of Form 2466;

(m) A record of any present or prior experience of providing workers by contract and for a fee in any state, by the person or any controlling person, and an explanation of that experience;

(n) A record of any bankruptcies, liens, or any actions involving or demonstrating dishonesty or misrepresentation, including but not limited to: fraud, theft, burglary, embezzlement, deception, perjury, forgery, counterfeiting, bribery, extortion, money laundering, or securities, investments, or insurance violations on the part of the person or any controlling person. Records of such actions must include:

(A) Charges, guilty pleas, or pleas of no contest;

(B) Criminal convictions;

(C) Lawsuits;

(D) Judgments; or

(E) Discharges or permitted resignations based on allegations of these actions.

(o) Full details regarding any bankruptcy, liens, or action under subsection (n), including:

(A) The nature and dates of the actions;

(B) Outcomes, sentences, and conditions imposed;

(C) Name and location of the court or jurisdiction in which any proceedings were held or are pending, and the dates of the proceedings; and

(D) The designation and license number for any actions against a license;

(p) Full details of any administrative actions against the person by a regulatory agency of any state regarding matters listed in subsection (n) or worker leasing activities;

(q) A plan of operation that demonstrates how the worker leasing company will meet the requirements of ORS chapter 654, The Oregon Safe Employment Act;

(r) A plan of operation that demonstrates how the worker leasing company will collect and report the information necessary to establish each client's separate experience rating to the insurer providing workers' compensation coverage for each client, or to the National Council on Compensation Insurance for a self-insured worker leasing company and

(s) A notarized signature of an authorized representative of the applicant.

(3) The director may request additional information to further clarify the information and documentation submitted with the application. Under ORS 656.850(2), no person may perform services as a worker leasing company in Oregon without first being licensed to do so.

(4) The director will review complete applications, and may conduct a background investigation of the person applying for a license, an owner, or any controlling person. Information learned through a background investigation, or other information submitted during the application process, may be the basis for the director to refuse to issue or renew a license, or to disqualify the person from making further application.

(5) If the application is approved, the director will issue a license. Each license issued under these rules will automatically expire two years after the date of issuance unless renewed by the licensee. To renew a license, the worker leasing company must submit a renewal application to the director at least 90 days before the expiration of the current worker leasing license. Any supplemental material, whether requested by the director or submitted by the worker leasing company to establish a complete application, must be received by the director at least 45 days before expiration of the current license.

(6) The director may refuse to issue or renew a license or may disqualify a person, controlling person, or worker leasing company from applying for a license in the future for misrepresentation, failure to meet any of the requirements of ORS 656.850, 656.855, or these rules, or for reasons including, but not limited to:

(a) Denial of a previous application for, or prior suspension or revocation of, a worker leasing license by the director;

(b) Denial, suspension, or revocation of a license, registration, or certification, or other discipline by any governmental agency or entity;

(c) Having exercised authority, control, or decision-making responsibility concerning any worker leasing company at the time that company had its authorization to provide worker leasing services denied, suspended, revoked, or restricted;

(d) Having been the subject of an order, adverse to the person, controlling person, or worker leasing company, by any governmental agency or entity in connection with any worker leasing activity;

(e) Having been found by any governmental agency or entity to have made a false or misleading statement, material misrepresentation, or material omission, or to have failed to disclose material facts;

(f) Violations of worker leasing statutes or regulations;

(g) Failure to establish minimum experience, training, or education that demonstrates competency in providing worker leasing services;

(h) Having been the subject of a complaint, investigation, or proceeding related to an action in subsection (2)(n) of this rule;

(i) Having been charged with, convicted of, or pleaded guilty or no contest to any felony or misdemeanor specified in subsection (2)(n) of this rule; or

(j) Having failed to provide documents the director has requested.

(7) "Disqualification," as used in this rule, means a person or a prospective worker leasing company may reapply no sooner than two years from the disqualification date.

(8) A disqualification may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person, owner, or controlling person.

(9) A person may appeal the director's refusal to approve and issue or renew a license, or a disqualification, under this rule as provided in OAR 436-050-0008 and 436-001.

Stat. Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0450
Recordkeeping and Reporting Requirements

(1) Every licensed worker leasing company must give notice to the director of one Oregon location where Oregon leasing records are kept and made available for review by the director. The notice must include the physical address, mailing address, telephone number, and any other contact information in this state.

(2) Every licensed worker leasing company must have at least one representative of the worker leasing company at the Oregon location authorized to respond to inquiries and make records available by the date specified in the director's request or demand for information regarding leasing arrangements and client contracts.

(3) The following records must be kept and made available for review at the Oregon location:

(a) Copies of signed worker leasing notices for the most recent three years;

(b) Copies of signed notices of termination of leasing arrangements for the most recent three years;

(c) Copies of signed contracts between the worker leasing company and clients for the most recent three years; and

(d) Payroll records for the most recent seven years for all workers that identify leased workers subject to coverage by the worker leasing company; leased workers not subject to coverage by the worker leasing company; and, written records for all regular and temporary employees of the worker leasing company.

(4) The worker leasing company must notify the director within 30 days of the effective date of a change in any items listed in OAR 436-050-0440(2).

Stat. Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0455
Reporting Requirements of a Self-Insured Worker-Leasing Company

(1) A self-insured worker leasing company must maintain and report to the National Council on Compensation Insurance separate statistical data for each client whose coverage is provided by the self-insured employer. Reporting must be according to the uniform statistical plan prescribed by the director according to ORS 737.225(4).

(2) Records relating to the client statistical data for self-insured worker leasing companies must be made available for review by the National Council on Compensation Insurance upon request.

Stat. Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0460
Suspension or Revocation of License

(1) Reasons for suspension or revocation of a worker leasing license include, but are not limited to:

(a) Insolvency, whether the worker leasing company's liabilities exceed their assets or the worker leasing company cannot meet its financial obligations;

(b) Judgments against or convictions, within the last ten years, of any worker leasing company or controlling person for the reasons identified in OAR 436-050-0440(2)(n);

(c) Administrative actions involving worker leasing activities resulting from failure to comply with the requirements of any state;

(d) Nonpayment of taxes, fees, assessments, or any other moneys due the State of Oregon;

(e) If the worker leasing company or controlling person has failed to comply with any provisions of ORS chapters 654, 656, 659, 659A, 731 or 737; or any provisions of these rules; or

(f) If the worker leasing company or controlling person is permanently or temporarily enjoined by a court from engaging in or continuing any conduct or practice involving any aspect of the worker leasing business.

(2) For the purposes of this rule:

(a) "Suspension" means a stopping by the director of the worker leasing company's or controlling person's authority to provide leased workers to clients for a specified period of time. A suspension may be in effect for a period of up to two years. When the suspension expires, the worker leasing company or controlling person may petition the director to resume its worker leasing company activities.

(b) "Revocation" means a permanent stopping by the director of the worker leasing company's or controlling person's authority to provide leased workers to clients. After a revocation has been in effect for five years or longer, the worker leasing company or controlling person may reapply for license.

(c) "Show-cause hearing" means an informal meeting with the director in which the worker leasing company will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a worker leasing company's authority to provide leased workers to clients.

(3) The director may revoke a license upon discovery of a misrepresentation in the information submitted in the worker leasing application.

(4) Suspension or revocation under this rule will not be made until the worker leasing company has been given notice and the opportunity to be heard through a show-cause hearing before the director and "show cause" why it should be permitted to continue to be licensed as a worker leasing company.

(5) A show-cause hearing may be held at any time the director finds that a worker leasing company has failed to comply with its obligations under a leasing contract or that it failed to comply with the rules or orders of the director.

(6) Appeal of proposed and final orders of suspension or revocation issued under this rule may be made as provided in OAR 436-050-0008 and OAR 436-001.

(7) Notwithstanding section (4) of this rule, the director may immediately suspend or refuse to renew a license by issuing an "emergency suspension order" if the worker leasing company fails to maintain workers' compensation coverage; or if the director finds there is a serious danger to public health or safety.

(8) A suspension or revocation may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person.

Stat. Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855

Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0470
Monitoring/Auditing

(1) The director will monitor and conduct periodic audits of employers as necessary to ensure compliance with the worker leasing company licensing and performance requirements.

(2) All pertinent records of the worker leasing company required by these rules must be disclosed upon request of the director.

(3) Under ORS 656.726 and 656.758, the director may inspect the books, records and payrolls of employers pertinent to the administration of these rules. Employers must provide the director with all pertinent books, records and payrolls upon request.

(4) For the purposes of this rule, both the worker leasing company and its clients will be considered employers.

Stat Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

436-050-0480
Assessment of Civil Penalties

(1) Failure to provide timely notice to the director for proof of coverage and cancellation of workers' compensation insurance policies under ORS 656.419 or OAR 436-162, or failure to provide timely worker leasing notice to the director under ORS 656.850(5) and OAR 436-050-0410, may result in civil penalties under ORS 656.745.

(2) The director may assess a civil penalty under ORS 656.745 against an employer who fails to respond to requests for information or fails to meet the requirements of 436-050-0470. Assessment of a penalty does not relieve the employer of the obligation to provide a response.

(3) An employer failing to meet the requirements set forth in OAR 436-050-0410, 436-050-0450, and 436-050-0455, may be assessed a civil penalty under ORS 656.745.

(4) An employer who is found to be operating a worker leasing company without having obtained a license or after having failed to renew a license, or who continues to operate in Oregon as a worker leasing company after a prior Oregon license expired, may be assessed a civil penalty for each violation under ORS 656.745.

(5) For the purposes of ORS 656.850(2), a violation is defined as any month or part of a month for each client in which an employer provides leased workers to a client without having first obtained a worker leasing license.

(6) An employer obtaining workers by contract and for a fee from an unlicensed worker leasing company on a non-temporary basis may be subject to penalties under ORS 656.745. Upon a subsequent or continuing violation where written notice of such violation has been served, penalties under ORS 656.745 will be assessed against the employer.

(7) Any person or controlling person may also be subject to penalties under ORS 656.990.

Stat. Auth.: ORS 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 5-2016, f. 11-28-16, cert. ef. 1-1-17

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Rule Caption: Amendment of rules governing claims administration
Adm. Order No.: WCD 6-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 10-1-2016
Rules Adopted: 436-060-0011
Rules Amended: 436-060-0003, 436-060-0005, 436-060-0008, 436-060-0010, 436-060-0015, 436-060-0017, 436-060-0018, 436-060-0019, 436-060-0020, 436-060-0025, 436-060-0030, 436-060-0035, 436-060-0040, 436-060-0045, 436-060-0055, 436-060-0060, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0137, 436-060-0140, 436-060-0147, 436-060-0150, 436-060-0153, 436-060-0155, 436-060-0160, 436-060-0170, 436-060-0180, 436-060-0190, 436-060-0195, 436-060-0200, 436-060-0400, 436-060-0500, 436-060-0510, 436-060-0009
Rules Repealed: 436-060-0001, 436-060-0002, 436-060-0006
Subject: The agency has amended OAR 436-060, "Claims Administration," to:

- Improve the clarity of the rules through improved organization, plain language, repeal of obsolete or redundant provisions, and definition of terms;
- Clarify procedures for requesting administrative review by the director;
- Clarify procedures for obtaining public records;
- State that a worker may choose a medical service provider, attending physician or authorized nurse practitioner under ORS 656.245, 656.260, OAR 436-010 and 436-015, and if an employer restricts that choice, the director may impose a civil penalty of up to $2000;
- Require an employer to provide form 801 to a worker upon receiving notice or knowledge of an accident that may involve a compensable injury;
- Require that electronic forms, when allowed, must include the same fields and elements as their paper counterparts;
- Specify that Form 1502, "Insurer's Report," must include the employer's policy number;
- Require the insurer to provide an email address with the information it sends to the worker when it changes claims processing location, service company, or self-administration;
- Provide that an electronically produced date is acceptable evidence of initial date of receipt;
- Provide that an insurer must respond to a worker's request for reclassification of a nondisabling claim within 14 days of the receipt of the request;
- Explain that if the worker is represented by an attorney, and the attorney is instrumental in obtaining an order from the director that reclassifies the claim from nondisabling to disabling, the director may award the attorney a reasonable assessed attorney fee under ORS 656.277;
- Provide that if an insurer fails to respond to a worker's request for reclassification of a nondisabling claim within 14 days of the receipt of the request, the worker may request review by the director as if the insurer issued a Notice of Refusal to Reclassify;
- Explain that the insurer must reimburse the employer for any employer-paid temporary disability benefits;
- Streamline process for calculating the rate of temporary total disability (TTD) compensation by:
  -- Providing that for all workers with irregular wages, or earnings that are not based on wages alone, the rate of TTD must be calculated based on the worker's total earnings for the period up to 52 weeks before the date of injury, with some restrictions; and
  -- Providing the insurer may not include any gap in employment of more than 14 days that was not anticipated in the wage earning agreement, when calculating the average earnings;
  -- Removing the provision that the rate of TTD for workers employed through union hall call boards must be computed based on a forty-hour work week;
- Clarify how to calculate temporary partial disability (TPD), the conditions requiring payment of TPD, and required notice to the worker and the worker's attorney when the insurer stops paying TTD and starts paying TPD;
- Clarify procedures for an insurer's election to process and pay or not to process and pay supplemental disability (SD) compensation, eligibility criteria for SD, procedures for processing SD requests, and calculation and payment of SD;
- Provide that an insurer or assigned processing administrator must determine a worker's eligibility for SD within 14 days of receipt of a worker's verifiable documentation, or the end of the 60-day period in the insurer's request for documentation if the worker does not

provide verifiable documentation, and notify the worker of the determination;

- Clarify requirements related to independent medical exams, including reimbursement of a worker's costs to attend the exam;

- Provide that if a worker begins cooperating with an insurer's investigation after payment of compensation to the worker has been suspended, the insurer is not required to notify the director, but must immediately reinstate the worker's benefits;

- Clarify requirements related to vocational evaluations of workers receiving permanent total disability, including reimbursement of a worker's costs to attend the evaluation;

- Clarify that a condition for eligibility for a worker requested medical exam is that the denial is based on one or more independent medical exam reports with which the worker's attending physician "did not concur;"

- Increase the number of days the worker or the worker's representative has to respond to the director's list of appropriate physicians for a worker requested medical exam from 10 to 14 days of the mailing date of the notice providing the list;

- Implement the change from quarterly to annual performance audits by:

-- Clarifying provisions for auditing insurers' claims processing performance;

-- Removing provisions for quarterly performance targets and penalties; and

-- Deleting the matrix for assessing penalties for number of quarters below standard performance level per year;

- Clarify requirements for timely payment of permanent disability and fatal benefits;

- Clarify requirements for payment of compensation when a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon;

- Provide that an employer may assume that a worker consents to having temporary disability benefits paid through a direct deposit system if that is the method the employer usually uses to pay the worker's wages;

- Remove the requirement that a worker must be able to make an initial withdrawal of the entire amount of an electronic deposit of compensation;

- Clarify requirements for requesting, processing, and issuing a penalty payable to a worker when the insurer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim;

- Require that insurers involved in claim responsibility disputes must mail claim documents to the other insurers under the time frames in OAR 436-060-0017; and

- Specify that amounts in a third-party recovery that result in overpayment of a worker are considered invalid payments of supplemental disability.

Rules Coordinator: Fred Bruyns—(503) 947-7717

436-060-0003
Purpose and Applicability of these Rules

(1) Purpose. The purpose of these rules is to prescribe uniform standards by which insurers process workers' compensation claims under ORS chapter 656.

(2) Applicability. The rules are subject to the applicability provisions under ORS 656.202.

(3) Director's discretion. The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth: ORS 656.210, 656.212, 656.230, 656.262, 656.264, 656.265, 656.268, 656.273, 656.277, 656.307, 656.325, 656.331, 656.704, 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0003, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-13-92, cert. ef. 2-1-92; WCD 1-1994(Temp), f. & cert. ef. 3-1-94; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 10-1995(Temp), f. & cert. ef. 8-18-95; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 14-1996(Temp), f. & cert. ef. 5-31-96; WCD 17-1996(Temp), f. 8-5-96, cert. ef. 8-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0005
Definitions

For the purpose of these rules unless the context requires otherwise:

(1) "Aggravation" means an actual worsening of the compensable conditions after the last award or arrangement of compensation that satisfies the requirements of ORS 656.273.

(2) "Authorized nurse practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and 436-010.

(3) "Designated paying agent" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.

(4) "Director" means the Director of the Department of Consumer and Business Services or the director's designee, unless the context requires otherwise.

(5) "Disposition" or "claim disposition" means the written agreement to release rights or obligations under ORS 656.236.

(6) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(7) "Employer" means a subject employer under ORS 656.023.

(8) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(9) "Inpatient" means a worker who is admitted to a hospital before and extending past midnight for treatment and lodging.

(10) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon; or an employer or employer group certified under ORS 656.430 that it meets the qualifications of a self-insured employer under ORS 656.407.

(11) "Mailed" or "mailing date," unless otherwise specified, means:

(a) The date a document is postmarked;

(b) The date automatically produced by electronic transmission (e.g., email or facsimile);

(c) The date a hand-delivered document is stamped or punched in by the recipient; or

(d) The date of a phone, or in-person request, when allowed under these rules.

(12) "Physical rehabilitation program" means any services provided to a worker to prevent the compensable injury from causing continuing disability.

(13) "Regularly employed worker" means any worker who receives a regular wage as defined in section (16) of this rule. For workers who are paid a daily wage, "regularly employed" means actual employment or availability for such employment.

(14) "Service company" means the contracted agent for an insurer authorized to process claims and make payment of compensation on behalf of the insurer.

(15) "Suspension of compensation" means:

(a) No temporary disability, permanent total disability, or medical and related service benefits accrue or are payable during the period of suspension; and

(b) Vocational assistance and payment of permanent partial disability benefits will stop during the period of suspension.

(16) "Wage" is as defined in ORS 656.005(29). As used in these rules:

(a) "Irregular wage" means a money rate paid at variable rate, or is paid on unscheduled or unpredictable intervals, including but not limited to workers who are seasonally employed, on call, paid hourly, or are paid by piece rate; and

(b) "Regular wage" means a money rate which is paid at a constant rate at uniform intervals including, but not limited to, wages paid on a daily or weekly basis. Hourly wages may be considered regular if the same number of hours are worked each pay period.

(17) "Wage earning agreement" means the verbal or written contract of hiring or terms of employment made between the worker and employer.

(18) "Written" means expressed in writing, including electronic transmission.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0005, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-922; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD

5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0008
Administrative Review and Contested Cases

(1) Request for hearing on an action concerning a worker's right to compensation. Any party, or assigned claims agent, that disagrees with an action taken under these rules that concerns a worker's right to compensation, or the amount of compensation due, may request a hearing by the Hearings Division under ORS chapter 656 and OAR chapter 438.

(2) Request for hearing on proposed sanctions or civil penalties. Any party, or assigned claims agent, that disagrees with a proposed order or proposed assessment of civil penalty of the director issued under ORS 656.254, 656.260, 656.735, 656.740, 656.745 or 656.750 may request a hearing by the Hearings Division. To request a hearing the party, or assigned claims agent, must:

(a) Mail or deliver a written request for hearing to the Workers' Compensation Division within 60 days of the mailing date of the proposed order or assessment; and

(b) Specify, in the request, the reasons why the party, or assigned claims agent, disagrees with the proposed order or assessment.

(3) Administrative review of a matter other than a matter concerning a claim. Any party, or assigned claims agent, that disagrees with an action taken under these rules, except as described in section (1) of this rule, may request the director to conduct an administrative review of the action.

(a) To request administrative review, the party must:

(A) Mail or deliver a written request for review to the Workers' Compensation Division within 90 days of the contested action; and

(B) Specify, in the request, the reasons why the party disagrees with the proposed order or assessment.

(b) Requests mailed more than 90 days after the contested action may be considered if the director determines there was good cause for delay, or that substantial injustice may otherwise result.

(4) Request for hearing on a matter other than a matter concerning a claim. Any party, or an assigned claims agent, that disagrees with an action or order of the director under these rules, other than as described in sections (1) and (2) of this rule, may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.245, 656.260, 656.704, 656.726(4) & 656.740(1)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78, WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0998, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0009
Access to Department of Consumer and Business Services Workers' Compensation Claim File Records

(1) General. Under ORS 192.430 and OAR 440-005-0015(1) the director, as custodian of public records, adopts this rule to protect the integrity of claim file records and prevent interference with the regular discharge of the department's duties.

(2) Access to public records. The department rules on Access of Public Records, Fees for Record Search and Copies of Public Records are found in OAR 440-005, accessible at: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_440/440_005.html.

(a) The director will provide the first copy of any document to a worker, worker's attorney, insurer of record, or the insurer's legal representatives and service companies without charge.

(b) Additional copies will be provided at the rates set forth in OAR 440-005. Payment of fees for access to records must be made in advance unless the director determines otherwise.

(3) Inspection of nonexempt public records. Any person has a right to inspect and obtain copies of nonexempt public records. The statutory right to "inspect" encompasses a right to examine original records. It does not include a right to request blind searches for records not known to exist.

(4) Inspection of exempt records. Workers' compensation claims records are exempt from public disclosure. Access to workers' compensation claims records will be granted at the sole discretion of the director in accordance with this rule, under the following circumstances:

(a) When necessary for insurers, service companies, and their legal representatives for the sole purpose of processing workers' compensation claims;

(b) When necessary for the director, other governmental agencies of this state or the United States to carry out their duties, functions or powers;

(c) When the disclosure is made in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim; or

(d) When a worker or the worker's attorney requests review of the worker's claim record.

(5) Release of records to other persons. The director may release workers' compensation claims records to persons other than those described in section (4) of this rule when the director determines such release is in the public interest and the conditions in ORS 192.502(20) and subsection (4)(c) of this rule have been met, including when workers' compensation claims file information is required by a public or private research organization in order to contact injured workers in order to conduct its research.

(a) The determination whether the request to release workers' compensation claims records meets those conditions is at the sole discretion of the director.

(b) The director may enter into written agreements as necessary to ensure that the recipient of workers' compensation claims records under this section uses or provides the information to others only in accordance with these rules and the agreement with the director, and to ensure the confidentiality of the disclosed records. The director may terminate such agreements at any time the director determines that one or more of the conditions of the agreement have been violated.

(6) Revocation of access to exempt records. The director may deny or revoke access to workers' compensation claims records at any time the director determines such access is no longer in the public interest or is being used in a manner that violates these rules or any law of the State of Oregon or the United States.

(7) Requests for records. A request to inspect or obtain copies of workers' compensation claim records may be made in writing, in person, or by phone.

(a) Written requests must include:

(A) The name, address, telephone number, and email address of the requester;

(B) The reason for requesting the records;

(C) A sufficiently detailed description of the records requested;

(D) The format and number of copies requested; and

(E) The account number of the requester, when applicable.

(b) In addition to the information required in subsection (a), a request made by telephone or facsimile transmission must include:

(A) The worker's Social Security number; and

(B) The insurer claim number.

(c) Except as prescribed in subsections (4)(a) through (d) of this rule, a request to inspect or obtain copies of a worker's claim record must be accompanied by an attorney retainer agreement or release signed by the worker.

(A) The director may refuse to honor any release the director determines is likely to result in disclosed records being used in a manner contrary to these rules.

(B) Upon request, the director will review proposed release forms to determine whether the proposed release is consistent with the law and this rule.

(8) Retention of records. The director will retain or destroy records according to retention schedules published by the Secretary of State, Archives Division.

Stat. Auth.: ORS 192.502, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0010
Employer Responsibilities

(1) General. A subject employer must accept notice of a claim for workers' compensation benefits from a worker or the worker's attorney under ORS 656.265.

(a) Form 801, "Report of Job Injury or Illness," must be readily available for workers to report their injuries. The employer must provide Form 801 to the worker:

(A) Immediately upon request by the worker or worker's attorney under ORS 656.265(6); and

(B) Upon receiving notice or knowledge of an accident that may involve a compensable injury under ORS 656.262(3)(a).

(b) Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," signed by the worker, is written notice of an accident that may involve a compensable injury under ORS 656.265. The signed Form 827 will start the claim process, but does not relieve the worker or employer of the responsibility of filing Form 801.

(c) The employer must provide Form 3283, "A Guide for Workers Recently Hurt on the Job," to the worker at the time a worker files a claim for workers' compensation benefits. Form 3283 may be printed on the back of Form 801.

(d) If a worker provides notice of a claim using an electronic form, the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records necessary to process the claim under OAR 436-010-0240.

(2) Employer reporting time frame. An employer, except a self-insured employer, must report a claim to its insurer no later than five days after the date the employer has notice or knowledge of any claim or accident that may result in a compensable injury. The date an employer has knowledge of an accident that may result in a compensable injury is the earliest date any supervisor or manager of the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility.

(3) Reporting requirements. The report must provide the information requested on Form 801, and include at least:

(a) The worker's name, address, and Social Security number;

(b) The employer's legal name and address; and

(c) The information required under ORS 656.262 and 656.265.

(4) Injuries not requiring medical services. The employer is not required to notify the insurer of an accident that does not require the worker to seek treatment from a licensed medical service provider, subject to the following:

(a) The employer must report the claim to the insurer under section (2) of this rule, if:

(A) The worker chooses to file a claim;

(B) The worker signs a Form 801;

(C) The worker or employer is billed for treatment; or

(D) The employer learns that the injury has resulted in medical services, disability or death. For the purposes of this paragraph, the date of that knowledge under section (2) of this rule is the date the employer received notice or knowledge of the medical services, disability, or death; and

(b) If the employer does not give the insurer notice under this section:

(A) The employer must maintain records showing the name of the worker, the date of the accident, the nature of the injury and treatment provided, for five years; and

(B) These records must be available for inspection by the director, the worker or the worker's attorney, if any, and the insurer.

(5) Civil penalty for failure to report claims. The director may assess a civil penalty under OAR 436-060-0200 against an employer that:

(a) Is late in reporting more than ten percent of its total claims to its insurer during any quarter; or

(b) Intentionally or repeatedly pays compensation instead of reporting claims or accidents that may result in a compensable injury to its insurer.

(6) Worker's right to choose medical service provider. The worker may choose a medical service provider, attending physician or authorized nurse practitioner under ORS 656.245, 656.260, OAR 436-010 and 436-015. Except as provided under ORS 656.260 and OAR 436-015, if an employer restricts the worker's choice of medical service provider the director may impose a civil penalty of up to $2,000.

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

Stat. Auth.: ORS 656.265(6), 656.726(4), 656.745

Stats. Implemented: ORS 656.245, 656.260, 656.262, 656.265

Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0100, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0011

Insurer Reporting Requirements

(1) General. The insurer must process and file claims and reports required by the director in compliance with ORS chapter 656, OAR chapter 436, and orders of the director.

(a) All forms must be legible and include all information required by this rule.

(b) The insurer may not submit forms, or their electronic equivalents, by email, facsimile, electronic data interchange (EDI), or other electronic means, without the director's prior authorization.

(c) Electronic forms, when allowed, must include the same fields and elements as their paper counterparts.

(2) Misdirected claims. If an insurer receives a claim and did not provide coverage for the worker's employer on the date of injury, the insurer must forward the claim to either the correct insurer or the director within three days of the date it determined it was not responsible for the claim.

(3) Identification of insurer. All workers' compensation forms generated by the insurer must include:

(a) The insurer's name;

(b) The service company's name, if applicable; and

(c) The mailing address and phone number of the location responsible for processing the claim.

(4) Claims status and activity reporting. The insurer must report all disabling claims status and activity to the director using Form 1502, "Insurer's Report."

(a) The insurer must file a Form 1502 with the director within 14 days of:

(A) The date of the insurer's initial decision to accept or deny the claim;

(B) The date of any reopening of the claim, except voluntary reopening under ORS 656.278;

(C) The date of a change in the acceptance or classification of the claim following the initial Form 1502;

(D) The date of a litigation order or insurer's decision that changes the acceptance or classification of the claim, or causes the claim to be reopened;

(E) The date a worker is enrolled in a managed care organization that occurs after the initial Form 1502 has been filed;

(F) The date the insurer has knowledge that a previously filed Form 1502 contained erroneous information;

(G) The date of a denial that occurs after the initial Form 1502 has been filed; or

(H) The date first payment of temporary disability is issued, if the date was not included in the initial Form 1502.

(b) Each Form 1502 the insurer files must include at least the following information:

(A) The worker's legal name;

(B) The worker's Social Security number;

(C) The insurer's claim number;

(D) The date of injury;

(E) The employer's legal name;

(F) The employer's policy number;

(G) The status of the claim; and

(H) The reason for filing.

(c) The Form 1502 reporting the insurer's initial decision to accept or deny a claim must also include:

(A) If the first payment of compensation was made within the time frame required under OAR 436-060-0150, if applicable;

(B) If the claim was accepted or denied within the time frame required under OAR 436-060-0140; and

(C) If the worker is enrolled in a managed care organization, and the date of enrollment, if applicable.

(5) Filing the first Form 1502 on a claim. The first Form 1502 the insurer files on a claim must be accompanied by:

(a) Copies of all acceptance or denial notices not previously submitted to the director; and

(b) A signed Form 801, or its electronic equivalent, except when a Form 801 is not available for timely filing.

(A) The Form 801 must be completed by the employer and worker, unless:

(i) The Form 801 cannot be obtained from the employer or worker because the employer or worker cannot be located, refuses to cooperate, or is physically unable to complete the form; or

(ii) The Form 801 was prepared using an electronic form that required it to be prepared by the insurer based upon information obtained from the employer and worker.

(B) If a Form 801 is not available for timely filing:

(i) The Form 1502 may be accompanied by a signed Form 827 to satisfy the initial reporting requirement; and

(ii) The Form 801 must be submitted within 30 days of the date the insurer filed the first Form 1502.

(6) Nondisabling claims. The insurer is not required to report a nondisabling claim to the director, except:

(a) The insurer must report a nondisabling claim that is denied in part or whole to the director within 14 days of the date of denial; and

(b) The insurer must report a nondisabling claim that is reclassified as disabling to the director within 14 days of the date of the status change.

(7) Voluntarily reopened own motion claims. The insurer must file Form 3501, "Notice of Voluntary Reopening Own Motion Claim," with the director within 14 days of the date the insurer voluntarily reopens a qualified claim under ORS 656.278.

(8) New condition reopening. If the insurer reopens a claim due to a new medical condition, and the claim:

(a) Is not closed within 14 days, the insurer must file Form 1502 with the director within 14 days of the earliest of:

(A) The date the new condition is accepted; or

(B) The date the insurer has knowledge that interim temporary disability compensation is due and payable; or

(b) Is closed within 14 days, the insurer must report the reopening on the Form 1503, "Insurer Notice of Closure Summary" filed with the director at the time the insurer closes the claim. The Form 1503 must be accompanied by the "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" sent to the worker.

(9) Claim withdrawal. The insurer must file a Form 1502 with the director if it receives written communication from the worker stating the worker never intended to file a claim and wants the claim withdrawn after the claim has been reported. The Form 1502 must be accompanied by a copy of the worker's communication.

(10) Failure to report. The director may issue a civil penalty against any insurer that does not file required notices and forms within the time frames of these rules.

(11) Reporting of legal service costs. Insurers must make an annual report to the director reporting attorney fees, attorney salaries, and all other costs of legal services paid under ORS chapter 656. The report must be submitted on forms provided by the director for that purpose. Reports for each calendar year must be filed by March 1 of the following year.

(12) Election of payment of supplemental disability. If an insurer elects to not process and pay supplemental disability benefits under ORS 656.210(5)(a) and OAR 436-060-0035:

(a) The insurer must submit Form 3530, "Supplemental Disability Election Notification," to the director. The insurer is not required to inform the director if it elects to process and pay supplemental disability unless the insurer has previously provided notice otherwise.

(b) The insurer must use Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," to request reimbursement under OAR 436-060-0500 for each quarter the insurer processed and paid supplemental disability benefits.

Stat. Auth.: ORS 656.264, 656.265(6), 656.726(4), 656.745
Stats. Implemented: ORS 656.210, 656.262, 656.264, 656.726(4)
Hist.: WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0015
Required Notice and Information

(1) Notice to worker's attorney. If a worker is represented by an attorney, and the attorney has given written notice of representation, the insurer must provide written notice to the worker's attorney before, or at the same time, as:

(a) The insurer requests the worker to submit to a medical examination;

(b) The insurer contacts the worker regarding any matter that may result in denial, reduction, or termination of the worker's benefits; or

(c) The insurer contacts the worker regarding any matter relating to the disposition of a claim under ORS 656.236.

(2) Penalty for failure to provide notice to worker's attorney. The director may assess a civil penalty against an insurer that intentionally or repeatedly fails to give notice as required under section (1) of this rule.

(3) Information provided to worker. The insurer or service company must provide:

(a) Form 1138, "What Happens if I'm Hurt on the Job?" to every worker who has a disabling claim with the first disability check or earliest written correspondence. For nondisabling claims, Form 3283, "A Guide for Workers Recently Hurt on the Job," may be provided in place of Form 1138, unless the worker specifically requests Form 1138;

(b) Form 3283 to its insured employers. Form 3283 may be printed on the back of Form 801;

(c) Form 3058, "Notice to Worker," or an equivalent form to the worker with the initial notice of acceptance of the claim under OAR 436-060-0140(6). If an equivalent form is provided, it must include all of the information included on Form 3058; and

(d) The additional notices required under OAR 436-060-0018, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, and 436-060-0180.

(4) Notice of change of processing location. When the insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, email address, and mailing address of the new claim processor.

(5) Notice of change in rate of compensation and benefit amounts. When the insurer changes the rate of compensation, the wage used to calculate benefit amounts, or the method of calculation used to determine benefits, the insurer must provide a written explanation of any change to the worker and the worker's attorney, if any.

(6) Notice of wage used to calculate benefits at closure. Before closure of a disabling claim the insurer must send a notice to the worker that:

(a) Documents the wage upon which benefits were based;

(b) Informs the worker that work disability, if applicable, will be determined when the claim is closed; and

(c) Explains how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 656.331, 656.726(4), 656.745
Stats. Implemented: ORS 656.331, 656.726(4)
Hist.: WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0017
Release of Claim Document

(1) Definitions. For the purpose of this rule:

(a) "Documents" means the written records making up, or relating to, the worker's claim, including but not limited to:

(A) Medical records;

(B) Vocational records;

(C) Payment ledgers for both temporary disability and medical services;

(D) Payroll records;

(E) Recorded statements;

(F) Insurer generated records, excluding a claims examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any privileged communications;

(G) All forms on the claim filed with the director;

(H) Notices of closure; and

(I) Electronic transmissions and correspondence between the insurer, service providers, claimant, director, or Workers' Compensation Board.

(b) Any documents generated or received by the insurer five or more working days before the mailing date of a request for copies of claims documents are considered to be in the insurer's or service company's possession, even if the documents have not reached the insurer's or service company's claim file.

(2) Date of receipt. The insurer or service company must display evidence of the initial date of receipt on each document in its possession.

(a) The evidence must include the month, day, year of receipt, and name of the company.

(b) Acceptable evidence under this section includes, but is not limited to, a machine produced date stamp or the data automatically produced by electronic transmission.

(3) Requests for claims documents. The insurer or service company must provide, without charge, legible copies of documents in its possession relating to a claim, upon request of the worker, worker's attorney or work-

er's beneficiary, at times other than those provided for under ORS 656.268 and OAR chapter 438, as provided in this rule.

(a) A request for copies of claim documents must be submitted to the insurer or service company, and copied simultaneously to the insurer's defense counsel, if known.

(b) Except as provided in OAR 436-060-0180, an initial request by anyone other than the worker or worker's beneficiary must be accompanied by an attorney retainer agreement or a medical release that has been signed by the worker.

(A) The signed medical release must be provided using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or an equivalent form.

(B) Information not otherwise available through this release, but relevant to the claim, may only be obtained in compliance with applicable state or federal laws.

(c) If the worker or beneficiary is represented by an attorney:

(A) The documents must be mailed directly to the worker's or beneficiary's attorney;

(B) The insurer is not required to provide copies to both the worker or beneficiary and the attorney; however, the insurer must inform the worker or beneficiary that the documents were mailed to the attorney if the documents were requested by the worker or beneficiary; and

(C) If the worker or beneficiary changes attorneys, the insurer must provide the new attorney with copies upon request.

(d) If the worker or beneficiary's attorney makes an ongoing request for documents:

(A) The insurer must provide all new documents received and generated by the insurer for 180 days after the initial mailing date under section (4) of this rule, or until a hearing is requested before the Workers' Compensation Board; and

(B) The insurer must provide new documents to the worker's attorney every 30 days. If the attorney requests that specific documents be sent more frequently, those documents must be provided within the time frame specified in section (4) of this rule.

(e) The insurer must provide to the worker or the worker's attorney the entire health information record in its possession, except the following, may be withheld:

(A) Information obtained from someone other than a health care provider under a promise of confidentiality and access to the information would likely reveal the source of the information;

(B) Psychotherapy notes;

(C) Information compiled for use in a civil, criminal, or administration action or proceeding; or

(D) Information that must be withheld under federal regulation.

(f) If a hearing is requested before the Workers' Compensation Board, the release of documents is controlled by OAR chapter 438 until the hearing request is withdrawn or the hearing record is closed, provided a request for documents is renewed.

(4) Time frame to provide documents. The insurer must provide copies of documents requested under this rule within the following time frames:

(a) Copies of documents from files that are not archived must be mailed within 14 days of receipt of a request;

(b) Copies of documents from archived files must be mailed within 30 days of receipt of a request;

(c) If a claim is lost or has been destroyed, the insurer must so notify the requester in writing within 14 days of receiving the request for claim documents. The insurer must reconstruct and mail the file within 30 days from the date of the lost or destroyed file notice; and

(d) If the insurer does not posses any documents at the time the request is received:

(A) The insurer must mail any documents relating to the claim it receives to the requestor within 14 days of receipt of the documents; and

(B) The request will be considered ongoing for 90 days.

(5) Complaints of violation. Complaints about a violation of the rules regarding release of requested claims documents must be made in writing, mailed or delivered to the division within 180 days of the request for documents, and must include a copy of the request submitted under section (3) of this rule.

(a) When notified by the director that a complaint has been filed, the insurer must mail or deliver a written response to the director within 14 days of the mailing date of the director's inquiry letter. A copy of the response, including any attachments, must be simultaneously mailed to the requester of claim documents.

(b) If the director does not receive a timely response or the insurer provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty against the insurer under OAR 436-060-0200. Assessment of a penalty does not relieve the insurer of the obligation to provide a response.

(6) Failure to provide documents. The director may assess a civil penalty against an insurer that fails to provide documents as required under this rule. The matrix attached to these rules in Appendix "A" will be used in assessing penalties.

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

Stat. Auth.: ORS 656.726(4), 656.745

Stats. Implemented: ORS 656.360, 656.362

Hist.: WCD 3-1991, f. 4-18-91, cert. ef. 6-1-91; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; ;WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0018

Nondisabling/Disabling Reclassification

(1) General. If the insurer changes the classification of an accepted claim:

(a) The insurer must notify the director under OAR 436-060-0011;

(b) The insurer must send the worker and the worker's attorney, if any, a "Modified Notice of Acceptance" explaining the change in status; and

(c) If the claim qualifies for closure, the insurer must close the claim under ORS 656.268(5).

(2) Reclassification of a nondisabling claim. The insurer must reclassify a nondisabling claim to disabling:

(a) Within 14 days of receiving information that:

(A) Temporary disability is due and payable;

(B) The worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability; or

(C) The worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary; or

(b) Upon acceptance of a new or omitted condition that meets the disabling criteria in this rule.

(3) Worker request for reclassification. A worker may request for the insurer to review the classification of a nondisabling claim under ORS 656.277 if the claim has been classified as nondisabling for one year or less after the date of acceptance and the worker believes the claim was or has become disabling.

(a) The request for classification status review must be made to the insurer in writing.

(b) Within 14 days of receipt of the worker's request, the insurer must review the claim and:

(A) If the classification is changed to disabling, provide notice under this rule; or

(B) If the insurer believes evidence supports denying the worker's request to reclassify the claim, the insurer must send a "Notice of Refusal to Reclassify" to the worker and the worker's attorney, if any. The notice must include the following statement, in bold print:

"If you disagree with this Notice of Refusal to Reclassify, you must appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing of this notice or you will lose your right to appeal. The address and telephone number of the Workers' Compensation Division are: [INSURER: Insert current address and telephone number of the Workers' Compensation Division, Appellate Review Unit, here.]."

(c) If the worker disagrees with the insurer's decision in the Notice of Refusal to Reclassify, the worker may appeal to the director under section (7) of this rule:

(A) The appeal must be made no later than the 60th day after the mailing date of the Notice of Refusal to Reclassify; and

(B) The appeal must include a copy of the insurer's Notice of Refusal to Reclassify.

(d) If the insurer does not respond to the worker's request for reclassification within 14 days of receipt of the worker's request:

(A) The worker may request review by the director under section (7) of this rule as if the insurer issued a Notice of Refusal to Reclassify;

(B) The director may assess civil penalties under OAR 436-060-0200;

(C) The director may assess an attorney fee under ORS 656.386(3); and

(e) If the worker is represented by an attorney, and the attorney is instrumental in obtaining an order from the director that reclassifies the

claim from nondisabling to disabling, the director may award the attorney a reasonable assessed attorney fee under ORS 656.277.

(4) Time frame for aggravation rights. A claim for aggravation under ORS 656.273 must be filed within five years after:

(a) The first valid closure of a claim that is reclassified from nondisabling to disabling within one year from the date of acceptance; or

(b) The date of injury of a claim that is not reclassified from nondisabling to disabling within one year from the date of acceptance.

(5) Claims for aggravation on nondisabling claims. When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation under ORS 656.273.

(6) Reclassification of a disabling claim. If a claim has been accepted and classified as disabling:

(a) All aspects of the claim are classified as disabling and may not be reclassified, unless:

(A) The claim has been classified as disabling for less than one year from date of acceptance;

(B) The insurer determines the criteria for a disabling claim were never satisfied; and

(C) The insurer has notified the worker and the worker's attorney, if any, by issuing a Modified Notice of Acceptance. The Modified Notice of Acceptance must advise the worker that he or she has 60 days from the date of the notice to appeal the decision;

(b) Any subsequently accepted conditions or aggravations must be processed as disabling claims; and

(c) Claim closure must be processed under ORS 656.268.

(7) Appeal of insurer's classification decision. If a worker disagrees with an insurer's decision to not reclassify the worker's claim from nondisabling to disabling, or to reclassify the claim from disabling to nondisabling, the worker may appeal the decision by requesting review by the director:

(a) The request must be in writing and mailed to the director within 60 days from the date of the insurer's notice;

(b) The worker may use Form 2943, "Worker Request for Claim Classification Review," for requesting review of the insurer's claim classification decision; and

(c) The worker does not need to be represented by an attorney to appeal the insurer's reclassification decision under section (3) or (6) of this rule. If a worker appeals an insurer's reclassification decision:

(A) The worker's appeal must be copied to the insurer;

(B) The director will acknowledge receipt of the appeal in writing to the worker, the worker's attorney, if any, and the insurer, and initiate the review;

(C) Within 14 days of the director's acknowledgement:

(i) The insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The director may impose penalties against an insurer under OAR 436-060-0200 if the insurer fails to provide claim documents in a timely manner; and

(ii) The worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time;

(D) After receiving and reviewing the required documents, the director will issue an order:

(i) The worker and the insurer have 30 days from the mailing date of the order to appeal the director's decision to the Hearings Division; and

(ii) The director may reconsider, abate, or withdraw any order before the order becomes final by operation of law.

Stat. Auth.: ORS 656.268, 656.277, 656.386, 656.726, 656.745
Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.262, 656.268, 656.386, 656. 273, 656.277, 656.745
Hist.: WCD 2-2004, f. 2-19-04, cert. ef. 2-29-04, Renumbered from 436-030-0045; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0019
Determining and Paying the Three Day Waiting Period

(1) Determining the three-day waiting period. The three-day waiting period is three consecutive calendar days, beginning with the first day the worker leaves work or loses wages as a result of the compensable injury, subject to the following:

(a) If the worker leaves work, but returns and completes the work shift without loss of wages, that day is not considered to be the first day of the three-day waiting period;

(b) If the worker leaves work, but returns and completes the work shift and receives reduced wages, that day is considered to be the first day of the three-day waiting period;

(c) If the worker leaves work and does not complete the work shift, that day is considered to be the first day of the three-day waiting period, even if there is no loss of wages;

(d) If the worker leaves work or loses wages during a work shift that extends into another calendar day, the first day of the three-day waiting period is the date the employer uses for payroll purposes.

(2) Authorization of temporary disability. Authorization of temporary disability under OAR 436-010-0210 is not required to begin the three-day waiting period.

(3) Paying the three-day waiting period. No temporary disability compensation is due the worker for the three-day waiting period, unless temporary disability is authorized under OAR 436-010-0210, and:

(a) The worker is totally disabled after the injury, and the total disability continues for a period of 14 consecutive days; or

(b) The worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability.

(4) Amount due when the three-day waiting period is payable. If compensation is due and payable for the three-day waiting period under section (3) of this rule:

(a) If the worker left work during the first half of the shift on the first day of the three-day waiting period, and did not return to complete the shift, the worker must be paid compensation for one half of that day; or

(b) If the worker left work during the second half of the shift on the first day of the three-day waiting period, the worker is not due compensation for that day;

(5) If the worker is employed with varying days off or a cyclic work schedule. If a worker is employed with varying days off or a cyclic work schedule, the three-day waiting period must be determined using the work schedule of the week the worker first leaves work or loses wages as a result of the injury.

(6) If the worker is no longer employed with the employer at injury. If the worker is no longer employed with the employer at injury, or does not have an established schedule when the worker leaves work or loses wages, the three-day waiting period and scheduled days off must be based on the work schedule of the week the worker was injured.

Stat. Auth.: ORS 656.210, 656.212, 656.726(4)
Stats. Implemented: ORS 656.210 & 656.212
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0020
Payment of Temporary Total Disability Compensation

(1) Employer payment of temporary disability. An employer may pay temporary disability compensation with the approval of the insurer. If the insurer approves an employer to make such payment:

(a) The insurer continues to be responsible for determining the worker's entitlement to compensation, and ensuring timely payment of compensation;

(b) The employer must provide the insurer with payment documentation that is adequate to meet the insurer's responsibilities; and

(c) The insurer must reimburse the employer for any temporary disability compensation paid to the worker under this section.

(2) Persons who have withdrawn from the workforce. No temporary disability is due and payable for any period of time in which the person has withdrawn from the workforce. For the purpose of this rule, a person who has withdrawn from the workforce, includes, but is not limited to:

(a) A person who, before reopening under ORS 656.267, 656.273 or 656.278, was not working and had not made reasonable efforts to obtain employment, unless such efforts would be futile as a result of the compensable injury.

(b) A person who was a full-time student for at least six months in the 52 weeks before the date of injury who elects to return to school full time, unless the person can establish a prior customary pattern of working while attending school. For purposes of this subsection, "full time" is defined as twelve or more quarter hours or the equivalent.

(3) Authorization of temporary disability compensation. No compensation is due and payable after the worker's attending physician or authorized nurse practitioner ceases to authorize temporary disability, or for any period of time when temporary disability benefits are not authorized by a medical service provider under ORS 656.245(2)(b). Temporary disability compensation is authorized when:

(a) The medical service provider provides the insurer or employer with oral or written verification of the worker's inability to work;

(b) Documents in the insurer's possession at claim closure reasonably reflect the worker's inability to work. For the purposes of this rule "docu-

ments" and "possession" have the same meaning as in OAR 436-060-0017(1); or

(c) The director determines, at reconsideration of claim closure, there is sufficient contemporaneous medical documentation to reasonably reflect the worker's inability to work under ORS 656.268.

(4) Lack of verification of inability to work. No temporary disability is due and payable for any period of time during which the insurer has requested from the worker's attending physician or authorized nurse practitioner verification of the worker's inability to work and the physician or authorized nurse practitioner cannot verify it, unless the worker has been unable to receive treatment for reasons beyond the worker's control.

(a) Before withholding temporary disability under this section, the insurer must ask the worker whether a reason beyond the worker's control prevented the worker from receiving treatment.

(A) If no valid reason is found or the worker does not respond or cannot be located, the insurer must document its file regarding those findings.

(B) The insurer must provide the director a copy of the documentation within 20 days, if requested.

(b) If the attending physician or authorized nurse practitioner is unable to verify the worker's inability to work, the insurer may stop temporary disability payments and, in place of the scheduled payment, must send the worker an explanation for stopping the temporary disability payments.

(c) When verification of temporary disability is received from the attending physician or authorized nurse practitioner, the insurer must pay temporary disability within 14 days of receiving the verification of any authorized period of temporary disability, unless otherwise denied.

(5) Suspension of benefits. An insurer may suspend temporary disability benefits without authorization from the director when all of the following circumstances apply:

(a) The worker has missed a regularly scheduled appointment with the attending physician or authorized nurse practitioner;

(b) The insurer has sent a letter by certified mail to the worker and a letter to the worker's attorney, at least 10 days in advance of a rescheduled appointment, stating that the appointment has been rescheduled with the worker's attending physician or authorized nurse practitioner; stating the time and date of the appointment; and giving the following notice, in prominent or bold face type:

> "You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice, as provided by ORS 656.262(4)(e)."

(c) The insurer verifies that the worker has missed the rescheduled appointment; and

(d) The insurer sends a letter to the worker, the worker's attorney and the division giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and the following notice, in prominent or bold face type:

> "Since you missed a regular appointment with your doctor, we arranged a new appointment. We notified you of the new appointment by certified mail and warned you that your benefits would be suspended if you failed to attend. Since you failed to attend the new appointment, your temporary disability benefits have been suspended. In order to resume your benefits, you must schedule and attend an appointment with your doctor who must verify your continued inability to work."

(6) Verbal release to work. If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician or authorized nurse practitioner, and the worker has not already been informed of the release by the attending physician or authorized nurse practitioner or returned to work, the insurer must:

(a) Document the facts;

(b) Communicate the release to the worker by mail within seven days. The communication to the worker of the negotiated return-to-work release may be contained in an offer of modified employment; and

(c) Advise the worker of their reinstatement rights under ORS chapter 659A.

(7) Temporary disability from two or more claims. When a worker is due concurrent temporary disability under ORS 656.210 or ORS 656.212 as a result of two or more accepted claims:

(a) The director may order one of the insurers to pay the entire amount of temporary disability due; or make a pro rata distribution between two or more of the insurers;

(b) The insurers may request for the director to make a pro rata distribution of compensation due. The request must be in writing, and the insurer must provide a copy to the worker and the worker's attorney, if any;

(c) The director's pro rata order does not apply to:

(A) Any periods of interim compensation payable under ORS 656.262; or

(B) Any benefits due under ORS 656.214 or 656.245;

(d) Claims subject to the pro rata order must be closed under OAR 436-030 and ORS 656.268, when appropriate;

(e) The pro rata distribution ordered by the director only applies to benefits due as of the date all claims involved are in an accepted status. The order pro rating compensation will not apply to periods where any claim involved is in a deferred status;

(f) The insurers may not prorate temporary disability without the approval of the director, except when the claims involve the same worker, the same employer, and the same insurer. When the insurer prorates temporary disability under this subsection the worker must receive compensation at the highest temporary disability rate of the claims involved.

(8) Premature closure. If a closure under ORS 656.268 has been found to be premature and there was an open ended authorization of temporary disability at the time of closure, the insurer must begin payments under ORS 656.262, including retroactive periods, and pay temporary disability for as long as authorization exists or until there are other lawful bases to terminate temporary disability.

(9) Incorrectly denied claims. If a denied claim has been determined to be compensable by final order, the insurer must begin temporary disability payments under ORS 656.262, including retroactive periods, if the authorization for temporary disability was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability.

Stat. Auth.: ORS 656.210(2), 656.245, 656.262, 656.726(4)
Stats. Implemented: ORS 656.210, 656.212, 656.262, 656.307(1)(c)
Hist.: WCB 12-1970, f. 9-21-70, ef. 10-25-70; 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0212, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90, Former sec. (6), (7), (8), (9) & (10) Renumbered to 436-060-0025(1) - (10); WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 10-1995(Temp), f. & cert. ef. 8-18-95; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 14-1996(Temp), f. & cert. ef. 5-31-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0025
Rate of Temporary Disability Compensation

(1) Continuation of wages, insured employers. An employer may not continue to pay wages in place of temporary disability benefits. However, with the consent of the worker, the employer may pay the worker amounts in addition to the temporary disability benefits due the worker, if:

(a) The employer identifies temporary disability benefits separately from other payments; and

(b) The employer does not withhold payroll deductions from the temporary disability benefits.

(2) Continuation of wages, self-insured employers. Notwithstanding section (1) of this rule, a self-insured employer may continue to pay the same wage at the same pay interval that the worker received at the time of injury. Such payment qualifies as timely payment of temporary disability under ORS 656.210 and 656.212. If the self-insured employer continues to pay wages in place of temporary disability benefits under this section:

(a) Normal deductions including but not limited to, taxes, benefits, and voluntary deductions, must be withheld;

(b) The claim must be classified as disabling;

(c) The self-insured employer must report to the division the rate and duration of temporary disability that would have been paid had wages not continued; and

(d) If the pay interval changes or the amount of wages decreases, the worker must be paid temporary disability as otherwise prescribed by the workers' compensation law.

(3) Rate of compensation, generally. Except when payments are made under section (2) of this rule, the worker must receive compensation as calculated under ORS 656.210 during the period of temporary total disability, subject to the following:

(a) The benefits of a worker who incurs an injury must be based on the worker's wages at the time of injury;

(b) The benefits of a worker who incurs an occupational disease must be based on the worker's wages at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease. If the worker is not working at the time that there is medical verification that the worker is unable to work because of the disability caused by the occupational disease, the benefits must be based on the worker's wages at the worker's last regular employment;

(c) The benefits of a worker who was employed in multiple jobs at the time of injury, and who is eligible for supplemental disability under ORS 656.210(2)(b) and OAR 436-060-0035, must be based on the worker's earnings from all eligible subject employment under OAR 436-060-0035;

(d) For a worker with a cyclic schedule, the cycle must be considered to have no scheduled days off; and

(e) When a work shift extends into another calendar day, the date of injury used to determine the wage under this section is the date the employer used for payroll purposes.

(4) Rate of compensation, irregular wages. If a worker receives irregular wages, or receives earnings that are not based on wages alone, the insurer must calculate the worker's rate of compensation under section (3) of this rule based on the weekly average of the worker's total earnings for the period up to 52 weeks before the date of injury or verification of disability caused by occupational disease.

(a) "Total earnings" means all wages, salary, commission and other remuneration for services rendered under the worker's wage earning agreement with the employer.

(A) The insurer must include a reasonable value of any in-kind considerations as part of total earnings only if the considerations will not continue during the period of disability.

(B) The insurer must not include expenses incurred due to the job and reimbursed by the employer (e.g., meals, lodging, per diem, equipment rental) as part of total earnings.

(b) If, on the date of injury or verification of disability caused by occupational disease, the worker had been employed by the employer at injury for four weeks or more, the insurer must average the workers' total earnings for the period up to 52 weeks of employment before the date of injury or verification of disability caused by occupational disease, subject to the following:

(A) The insurer may not include any gap in employment of more than 14 days that was not anticipated in the wage earning agreement, when calculating the average earnings; and

(B) If the worker's wage earning agreement changed due to reasons other than only a change in rate of pay, including but not limited to a change of hours worked or a change of job duties, in the 52 weeks before the date of injury or verification of disability caused by occupational disease, the insurer must average earnings only for the weeks worked under the most recent wage earning agreement; and

(C) For the purposes of this section, a job assignment from a temporary service provider or worker leasing company as defined in OAR 436-050 is not considered to be a new wage earning agreement.

(c) If, on the date of injury or verification of disability caused by occupational disease, the worker had been employed by the employer at injury for less than four weeks, or the worker's wage earning agreement had been in place less than four weeks, the insurer must base the rate of compensation on the intent of the worker's wage earning agreement in place at the time of injury, as confirmed by the employer and the worker.

(5) Rate of compensation, regular wages. If a worker receives regular wages, the insurer must calculate the worker's rate of compensation as outlined in ORS 656.210. To determine the worker's weekly wage:

(a) Daily wages must be multiplied by the number of days per week the worker was regularly employed;

(b) Monthly wages must be divided by 4.35; or

(c) Wages for other pay intervals must be calculated on an equivalent basis.

(6) Workers with no wages. If the worker is a volunteer, inmate, or other covered worker that receives no wage earnings, the insurer must calculate the rate of compensation based on the assumed wage used to determine the employer's premium.

(7) Owners and corporate officers. If the worker is a sole proprietor, partner, officer of a corporation, or limited liability company member, the insurer must calculate the rate of compensation based on the assumed wage used to determine the employer's premium.

(8) Wage disputes. If the worker disputes the wage used to calculate the rate of compensation, the insurer must attempt to resolve the dispute by contacting the employer to confirm the correct wage and then contacting the worker with that information. If the worker still does not agree with the wage calculated by the insurer, the worker may request a hearing under OAR 436-060-0008.

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

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.210(2), 656.704 & 656.726(4)

Stats. Implemented: ORS 656.210, 656.704

Hist.: WCB 12-1970, f. 9-21-70, ef. 10-25-70; 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0212, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90, Renumbered from 436-060-0020 former sections (6), (7), (8), (9) & (10); WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0030

Payment of Temporary Partial Disability Compensation

(1) Rate of temporary partial disability. The amount of temporary partial disability compensation due a worker must be determined by multiplying the worker's rate of compensation for temporary total disability by the percentage of wages lost by the worker post injury.

(a) To calculate the rate of temporary disability, the insurer must:

(A) Subtract the worker's post-injury wages from any kind of work from the worker's wages at the time of injury under OAR 436-060-0025;

(B) Divide the difference under paragraph (A) by the worker's wages at the time of injury under OAR 436-060-0025 to arrive at the percentage of loss of wages; and

(C) Multiply the worker's current rate of compensation for temporary total disability by the percentage of loss of wages in paragraph (B).

(b) As used in this rule "post-injury wages" means the sum of:

(A) The wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater;

(B) Any unemployment benefits received; and

(C) Any wages received for paid leave, except wages paid in addition to temporary disability compensation with the worker's consent under OAR436-060-0025(1);

(c) Wages from a secondary employer must only be included in post-injury wages to the extent that the wages from the secondary employer post-injury exceed the wages from the secondary employer at the time of injury.

(d) If the worker's rate of temporary total disability compensation is based on an assumed wage, the rate of temporary partial disability must be calculated by multiplying the rate of temporary total disability by the percentage of hours lost by the worker post injury.

(2) If the worker returns to employment. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation from the date an injured worker returns to regular or modified employment, prior to claim closure.

(a) If the worker is with a new employer, and the insurer asks the worker to provide wage information, the worker is responsible for providing documented evidence of the amount of any wages being earned; and

(b) If the worker fails to provide documentation, the insurer may assume that post-injury wages are the same as or higher than the worker's wages at time of injury.

(3) If the worker fails to begin employment. Except when the worker refuses modified work under ORS 656.268(4)(c), the insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date a worker fails to begin regular or modified employment, and the following conditions have been met:

(a) The employer or insurer:

(A) Notifies the attending physician or authorized nurse practitioner of the physical tasks to be performed by the injured worker;

(B) Notifies the attending physician or authorized nurse practitioner of the location of the modified work offer; and

(C) Asks the attending physician or authorized nurse practitioner if the worker can, as a result of the compensable injury, physically commute to and perform the job.

(b) The attending physician or authorized nurse practitioner has agreed the employment appears to be within the worker's capabilities, and considering the compensable injury the worker is physically able to commute the lesser of:

(A) The distance from the worker's residence at the time of injury to the work site; or

(B) The distance from a worker's residence at the time of the modified work offer to the work site; and

(c) The employer or insurer has confirmed the offer of employment in writing to the worker stating:

(A) The beginning time, date and place;

(B) The duration of the job, if known;

(C) The wages;

(D) An accurate description of the physical requirements of the job;

(E) That the attending physician or authorized nurse practitioner has found the job to be within the worker's capabilities and the commute to be within the worker's physical capacity;

(F) The worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:

(i) The offer is at a site more than 50 miles from the location where the worker was injured or where the worker customarily reported for work, unless the work site is less than 50 miles from the worker's residence, or the job at the time of injury involved multiple or mobile work sites as established by the intent of the employer and worker at the time of hire or the employment pattern before the injury;

(ii) The offer is not with the employer at injury;

(iii) The offer is not at a work site of the employer at injury;

(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or

(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and

(G) The following notice, in prominent or bold face type:

"If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reasons for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's actions to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282."

(4) If the worker has been terminated from employment. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date the worker's attending physician or authorized nurse practitioner approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:

(a) The employer has a written policy of offering modified work to injured workers;

(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1) of this rule;

(c) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks to be performed by the injured worker; and

(d) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.

(5) If the worker is in violation of federal immigration law. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:

(a) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1) of this rule;

(b) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and

(c) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.

(6) If the modified job no longer exists or offer is withdrawn. Temporary partial disability must be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer.

(a) This section applies to situations including, but not limited to, termination of temporary employment, layoff, or plant closure.

(b) A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim is subject to this section.

(c) For the purpose of this rule, when a worker who has been doing modified work quits the job, or the employer terminates the worker for violation of work rules or other disciplinary reasons, it is not a withdrawal of a job offer by the employer, but must be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a).

(d) This section does not apply to those situations described in sections (3), (4), and (5) of this rule.

(7) Termination of temporary partial disability. When the worker's disability is partial only and temporary in character, temporary partial disability compensation under ORS 656.212 must continue until:

(a) The attending physician or authorized nurse practitioner verifies that the worker can no longer perform the modified job and is again temporarily totally disabled;

(b) The compensation is terminated by order of the director or by claim closure under ORS 656.268; or

(c) The compensation is lawfully suspended, withheld or terminated for any other reason.

(8) Verbal release to work. If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician or authorized nurse practitioner, and the worker has not already been informed of the release by the attending physician or authorized nurse practitioner or returned to work, the insurer must:

(a) Document the facts;

(b) Communicate the release to the worker by mail within seven days; the communication to the worker of the negotiated return to work release may be contained in an offer of modified employment; and

(c) Advise the worker of their reinstatement rights under ORS chapter 659A.

(9) Changes in the rate of compensation. When the insurer stops paying temporary total disability compensation and starts paying temporary partial disability compensation, or otherwise changes the compensation rate or the method of computation of benefits under this rule, the insurer must send written notice to the worker and worker's attorney under OAR 436-060-0015.

Stat. Auth.: ORS 656.212, 656.704 & 656.726(4)

Stats. Implemented: ORS 656.212, 656.268, 656.325(5), 656.704, 656.726(4)

Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0222, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 1-1994(Temp), f. & cert. ef. 3-1-94; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 10-1995(Temp), f. & cert. ef. 8-18-95; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0035

Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) Definitions. For the purpose of this rule:

(a) "Primary job" means the job at which the injury occurred, or the job where the worker was employed at the time of medical verification that the worker is unable to work because of disability caused by occupational disease;

(b) "Secondary job" means any other job held by the worker in Oregon subject employment at the time of injury;

(c) "Temporary disability" means wage loss replacement for the primary job.

(d) "Supplemental disability" means wage loss replacement for the secondary jobs that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210; and

(e) "Insurer" has the same meaning as OAR 436-060-0005(10), and also includes service companies.

(2) Election to process and pay supplemental disability. An insurer may elect to be responsible for payment and processing of supplemental disability benefits to a worker employed in more than one job at the time of injury. The insurer must report their election to the director under OAR 436-060-0011(12).

(a) The election must be made by the insurer, and applies to all service companies an insurer may use for processing claims.

(b) The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election. An insurer may change its election once after the director's first audit of supplemental disability payments made by the insurer and once each following year.

(c) If the insurer has elected to process and pay supplemental disability benefits:

(A) The insurer must determine the worker's ongoing entitlement to supplemental disability;

(B) The insurer must pay the worker supplemental disability benefits simultaneously with any temporary disability benefits due;

(C) The insurer must maintain a record of supplemental disability benefits paid to the worker, separate from temporary disability benefits paid as a result of the job at injury; and

(D) The director will reimburse the insurer for supplemental disability paid under OAR 436-060-0500.

(d) If the insurer has elected not to process and pay supplemental disability benefits:

(A) The director will select an assigned processing administrator who is authorized to process and pay supplemental disability benefits on behalf of the director;

(B) The assigned processing administrator must determine the worker's ongoing entitlement to supplemental disability and must pay the worker supplemental disability benefits due once each 14 days; and

(C) The insurer and assigned processing administrator must cooperate and communicate, as necessary, to coordinate benefits due.

(i) The assigned processing administrator must provide the insurer with any verifiable documentation of wages from a secondary job received from the worker; and

(ii) The insurer and assigned processing administrator must retain documentation of shared information.

(3) Eligibility for supplemental disability. A worker who was employed at one or more secondary jobs with Oregon subject employers at the time of injury or medical verification of an occupational disease may be eligible to receive supplemental disability if:

(a) The worker provides notification of the secondary job to the insurer within 30 days of the insurer's receipt of the initial claim;

(b) The rate of compensation for wages at the primary job under OAR 436-060-0025 is less than the maximum temporary disability rate established under ORS 656.210; and

(c) The worker provides verifiable documentation of the wages from any secondary jobs at the time of injury or medical verification of an occupational disease within 60 days of the mailing date of the request for documentation sent under section (4) of this rule. For each secondary job, the documentation must:

(A) Identify the Oregon subject employer for each secondary job;

(B) Establish that the worker held the secondary job, in addition to the primary job, at the time of injury or medical verification of occupational disease; and

(C) Provide adequate information to calculate the average weekly wage under OAR 436-060-0025.

(4) Determination of eligibility. Upon receiving notification of a worker's secondary job the insurer must determine the rate of temporary disability compensation for wages at the primary job under OAR 436-060-0025, and:

(a) If the rate of temporary disability compensation meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits; or

(b) If the rate of temporary disability is less than the maximum temporary disability rate, the worker may be eligible for supplemental disability benefits. If the worker may be eligible for supplemental disability benefits, the insurer must:

(A) Send the worker a request for verifiable documentation of the worker's wages from any secondary jobs within five business days of notice or knowledge that the worker may be eligible for supplemental disability benefits;

(i) The request must inform the worker what verifiable documentation the worker must submit to the insurer or assigned processing administrator, to determine the worker's eligibility for supplemental disability;

(ii) The request must clearly state that if the insurer or assigned processing administrator does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred, and the worker will be found ineligible for supplemental disability;

(B) If the insurer has elected not to process and pay supplemental disability benefits under section (2) of this rule, the insurer must also send a copy of the request to the assigned processing administrator. In addition to the requirements of this section, the request must also:

(i) Contain the name, address, email address, and telephone number of the assigned processing administrator;

(ii) Clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator; and

(C) The insurer or assigned processing administrator must determine the worker's eligibility for supplemental disability within 14 days of:

(i) Receipt of the worker's verifiable documentation; or

(ii) The end of the 60-day period in the insurer's request, if the worker does not provide verifiable documentation.

(c) Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this section will not result in a penalty under ORS 656.262(11).

(5) Notification of eligibility determination. The insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the determination to the worker and the worker's attorney, if any, in writing. If the worker is found ineligible for supplemental disability, the letter must also advise the worker of the reason why they are not eligible, and how to appeal if the worker disagrees with the determination.

(6) Calculation of supplemental disability. The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding the weekly averages of the worker's wages from each secondary job as calculated under OAR 436-060-0025. For the purposes of calculating and payment of supplemental disability:

(a) The total rate of supplemental disability may not exceed the difference between the maximum rate of temporary disability under ORS 656.210(1) and the rate of compensation for wages under the worker's primary job;

(b) No supplemental disability is due for jobs where the rate of compensation is based on an assumed wage;

(c) In no case may an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer;

(d) The worker's scheduled days off for the primary job must be used to calculate and pay supplemental disability; and

(e) No three-day waiting period applies to supplemental disability benefits.

(7) Partial disability. When a worker who is eligible to receive supplemental disability benefits has post-injury wages from either the primary job or any secondary job:

(a) The insurer or the assigned processing administrator must calculate the rate of temporary partial disability due the worker under OAR 436-060-0030 based on the worker's wages from both the primary and secondary jobs;

(b) The insurer or the assigned processing administrator must calculate the amount of supplemental disability by subtracting the rate of partial disability due based on wages from only the primary job from the total rate of compensation due the worker;

(c) If the worker receives post-injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due; and

(d) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

(8) If temporary disability is not due from the primary job. Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job.

(a) A nondisabling claim will not change to disabling status due to payment of supplemental disability.

(b) When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

(9) Worker's responsibilities. A worker who is eligible for supplemental disability under this rule has an ongoing responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

(10) Hearings. If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker may request a hearing under OAR 436-060-0008.

(a) If the worker requests a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit an appeal of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule.

(b) The insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.

(11) Sanctions. An insurer that elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if

the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.

(12) Third party recovery. In the event of a third party recovery:

(a) Previously reimbursed supplemental disability benefits are a portion of the paying agency's lien; and

(b) Remittance on recovered benefits must be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and ORS 656.593.

Stat. Auth.: ORS 656.210, 656.726(4)
Stats. Implemented: ORS 656.210, 656.212, 656.325(5), 656.704, 656.726(4)
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 6-2002(Temp), f. 4-22-02, cert. ef. 5-10-02 thru 11-5-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0040
Payment of Permanent Partial Disability Compensation

(1) General. A permanent partial disability award exceeding $6,000 may be paid monthly by the insurer. If it is paid monthly, it must be paid at 4.35 times the weekly temporary disability rate at the time of closure. A permanent partial disability award less than $6,000 must be paid under OAR 436-060-0060.

(2) Reopened claims. If a claim is reopened as a result of a new medical condition, or an aggravation of the conditions resulting from the worker's compensable injury:

(a) Any permanent partial disability benefits due must continue; and

(b) If any temporary disability benefits are due, permanent partial disability benefits must be paid concurrently.

(3) Training programs. If the worker begins a training program after claim closure, the insurer must suspend the payment of any work disability award, but continue to pay any impairment award. The insurer must stop temporary disability compensation payments and resume any award payments suspended under ORS 656.268(10) upon the worker's completion or ending of the training, unless the worker is not then medically stationary.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.216, 656.268(10), 656.704, 656.726(4)
Hist.: WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0232, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16

436-060-0045
Payment of Compensation During Worker Incarceration

(1) General. A worker is not eligible to receive temporary disability compensation for periods of time during which the worker is incarcerated for commission of a crime. All other compensation benefits must be provided the worker as if the worker were not incarcerated, except as provided in OAR 436-120. For the purpose of this rule:

(a) A worker is incarcerated for commission of a crime when:

(A) In pretrial detention; or

(B) Imprisoned following conviction for a crime; and

(b) A worker is not incarcerated if the worker is on parole or work release status.

(2) Initiation of payments after incarceration. Temporary disability compensation, if due and payable, must be paid the worker within 14 days of the date the insurer becomes aware the worker is no longer incarcerated.

(3) Right to claim closure. A worker who is incarcerated has the same right to claim closure under ORS 656.268 as a worker who is not incarcerated. Any permanent disability awarded must be paid the same as if the worker were not incarcerated.

Stat. Auth.: ORS 656.160, 656.704, 656.726(4)
Stats. Implemented: ORS 656.160, 656.704, 656.726(4)
Hist.: WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 19-1990(Temp), f. & cert. ef. 9-18-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0055
Payment of Medical Services on Nondisabling Claims; Employer/Insurer Responsibility

(1) General. Notwithstanding the choice made by the employer under this rule, the employer and insurer must process nondisabling claims in accordance with all statutes and rules governing claims processing. The employer, however, may reimburse the medical service costs paid by the insurer as prescribed in section (3) of this rule.

(2) Notice to employers. Before the beginning of each policy year, the insurer must notify the insured or prospective insured employer of the employer's right to reimburse medical service costs on accepted, nondisabling claims up to the maximum amount as published in Bulletin 345. The notice must advise the employer:

(a) Of the procedure for making such payments as outlined in section (3) of this rule;

(b) Of the general impact on the employer if the employer chooses to make such payments;

(c) That the employer is choosing not to participate if the employer does not respond in writing within 30 days of receipt of the insurer's notice;

(d) That the employer's written election to participate in the reimbursement program remains in effect, without further notice from the insurer, until the employer advises otherwise in writing or is no longer insured by the insurer; and

(e) That the employer may participate later in the policy period upon written request to the insurer, however, the earliest reimbursement period is the first completed period, established under subsection (3)(a) of this rule, following receipt of the employer's request.

(3) Procedure for reimbursement. If the employer wishes to reimburse the medical service costs paid by the insurer, and has advised the insurer of their election to participate in the reimbursement program in writing under section (2) of this rule:

(a) Within 30 days following each three month period after policy inception or a period mutually agreed upon by the employer and insurer, the insurer must provide the employer with a list of all accepted nondisabling claims for which payments were made during that period and the respective cost of each claim;

(b) The employer, no later than 30 days after receipt of the list, must identify those claims and the dollar amount the employer wishes to pay for that period and reimburse the insurer accordingly. The employer and insurer may, by written agreement, establish a period in excess of 30 days for the employer to reimburse the insurer;

(c) Failure by the employer to reimburse the insurer within the 30 days allowed by subsection (b) will be deemed notice to the insurer that the employer does not wish to make a reimbursement for that period; and

(d) The insurer must continue to bill the employer for any payments made on the claims within 27 months of the inception of the policy period. Any further billing and reimbursement will be made only by mutual agreement between the employer and the insurer.

(4) Records. The insurer must maintain records of amounts reimbursed by employers for medical services on nondisabling claims. For medical service costs reimbursed under this rule:

(a) The insurer may not modify an employer's experience rating or otherwise make charges against the employer based on the costs; and

(b) If the employer is on a retrospective rated plan, the medical costs paid by the employer on nondisabling claims must be included in the retrospective premium calculation, but the insurer must apply the amount paid by the employer as credits against the resulting retrospective premium.

(5) Reclassified claims. If a claim changes from a nondisabling to a disabling claim and the insurer has recovered reimbursement from the employer for medical costs billed by the insurer before the change, the insurer must exclude those amounts reimbursed from any experience rating, or other individual or group rating plans of the employer. If the employer is on a retrospective rated plan, the premium must be calculated as provided in section (4) of this rule.

(6) Penalties. Insurers that do not comply with the requirements of this rule or in any way prohibit an employer from reimbursing the insurer under section (3) of this rule, may be subject to a penalty as provided by OAR 436-060-0200(7).

(7) Self-insured employers. Self-insured employers must maintain records of all amounts paid for medical services on nondisabling claims under OAR 436-050-0220. When reporting loss data for experience rating, the self-insured may exclude costs for medical services paid on nondisabling claims in amounts not to exceed the maximum amount published in Bulletin 345.

Stat. Auth.: ORS 656.262(5), 656.704, 656.726(4), 656.745
Stats. Implemented: ORS 656.262(5), 656.704 & 656.726(4), Ch. 518 OL 2007
Hist.: WCD 10-1987(Temp), f. 12-18-87, ef. 1-1-88; WCD 4-1988, f. 6-27-88, cert. ef. 7-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0060
Lump Sum Payment of Permanent Partial Disability Awards

(1) General. When an award for permanent partial disability is $6,000 or less, the insurer must pay the total amount of the award to the worker in a lump sum. When the award for permanent partial disability exceeds $6,000, the worker or worker's attorney may request a lump sum payment of all or part of the award. The insurer may only deny the request for lump sum payment if any of the following apply:

(a) The worker has not waived the right to appeal the adequacy of the award;

(b) The award has not become final by operation of law;

(c) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(d) The worker is enrolled and actively engaged in training according to the rules adopted under ORS 656.340 and 656.726. For dates of injury before January 1, 2005, the insurer may not approve a request for lump sum payment of unscheduled permanent disability. For dates of injury on or after January 1, 2005, the insurer may not approve a request for lump sum payment of work disability when the worker:

(A) Has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request;

(B) Is actively enrolled and engaged in a vocational training program under OAR 436-120; or

(C) Has temporarily withdrawn from a vocational training program.

(2) Application for approval. When an insurer receives a request for a lump sum payment from the worker or the worker's attorney, the insurer must send Form 1174, "Application for Approval of Lump-sum Payment of Award," to the requestor within 10 business days.

(3) Reopening of claims. For the purpose of this rule, each opening of the claim is considered a separate claim and any subsequent permanent partial disability award from a claim reopening is a new and separate award. Additional award of permanent partial disability obtained through the appeal process is considered part of the total cumulative award for the open period of that claim.

(4) Approved requests. If the insurer approves the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, the insurer must make the lump sum payment within 14 days of receipt of the signed application.

(5) Denied requests. If the insurer denies the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, the insurer must respond to the requestor within 14 days of receiving the request explaining the reason for denying the lump sum request.

(6) Claim disposition agreements. A lump sum payment ordered in a litigation order or that is a part of a claim disposition agreement under ORS 656.236 does not require further approval by the insurer.

(7) Partial payments. When a lump sum payment for only part of an award is approved by the insurer, it must be paid in addition to the regularly scheduled monthly payment. The remaining balance must be paid under ORS 656.216. Denial or partial approval of a request does not preclude another request by the worker for a lump sum payment of all or part of any remainder of the award, provided additional information is submitted.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.230, 656.704, 656.726(4)
Hist.: WCB 6-1966, f. & ef. 6-24-66; WCB 5-1974, f. 2-13-74, ef. 3-11-74; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0250, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0095
Medical Examinations; Suspension of Compensation; and Insurer Medical Examination Notice

(1) General. A worker must submit to independent medical examinations reasonably requested by the insurer or the director.

(a) The conditions of the examination must be consistent with conditions described in OAR 436-010-0265.

(b) If the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1), the director may suspend compensation by order:

(A) The worker must have the opportunity to dispute the suspension of compensation before the director will issue the order; and

(B) Compensation will be suspended until the examination has been completed. The worker is not entitled to compensation during or for the period of suspension.

(c) Any action of a worker's observer allowed under OAR 436-010-0265(5) that obstructs the examination may be considered an obstruction of the examination by the worker for the purpose of this rule.

(d) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(2) Number of examinations. The insurer may request no more than three separate independent medical examinations for each opening of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(8).

(3) Scheduling and notice to worker. The insurer may contract with a third party to schedule independent medical examinations. When an examination is scheduled by the insurer, or by a third party at the request of the insurer:

(a) The worker and the worker's attorney, if any, must be simultaneously notified in writing of the scheduled medical examination;

(b) The notice must be mailed at least 10 days before the examination;

(c) If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice must be sent on the insurer's stationery; and

(d) The notice sent for each appointment, including those which have been rescheduled, must contain the following:

(A) The name of the examiner or facility;

(B) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;

(C) The date, time and place of the examination;

(D) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(E) If applicable, confirmation that the director has approved the examination;

(F) A statement that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;

(G) A statement that an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence;

(H) A statement that the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer; and

(I) The following notice in prominent or bold face type:

"You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers' compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a $100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.

If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombudsman for Injured Workers at 1-800-927-1271."

(e) The insurer must include with each appointment notice it sends to the worker:

(A) Form 3921, "Request for Reimbursement of Expenses," or a similar form for requesting reimbursement; and

(B) Form 3923, "Important Information about Independent Medical Exams."

(4) Reimbursement of costs. The insurer must reimburse the worker for a reasonable cost of public transportation or use of a private vehicle and, when necessary, a reasonable cost of child care, meals, lodging and other related services.

(a) To be reimbursed, the worker must submit a request for reimbursement accompanied by a sales slip, receipt or other evidence necessary to support the request.

(b) If an advance of these costs is necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance.

(c) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, are considered to be reasonable under this rule.

(5) Requests to authorize suspension. The director will consider requests to authorize suspension of benefits on accepted claims, deferred claims, and denied claims in which the worker has appealed the insurer's denial. The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service in the same manner as a summons. The request must include the following information:

(a) That the insurer requests suspension of compensation under ORS 656.325 and OAR 436-060-0095;

(b) The claim status and any accepted or newly claimed conditions;

(c) What specific actions of the worker prompted the request;

(d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;

(e) A copy of any approvals given by the director for more than three independent medical examinations, or a statement that no approval was necessary, whichever is appropriate;

(f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;

(h) A copy of the notice required in section (3) and a copy of any written verification received under subsection (5)(g) of this rule;

(i) Any other information that supports the request; and

(j) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."

(6) Effective date of suspension. If the director authorizes the suspension of compensation, the suspension will be effective from the date the worker fails to attend an examination or such other date the director deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.

(7) Reinstatement of benefits. The insurer must assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the independent medical examination, the insurer must verify the worker's participation and reinstate compensation effective the date of the worker's compliance.

(8) Claim closure. If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the mailing date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034(8).

(9) Denial of suspension. If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(10) Other actions by the director. The director may also take the following actions concerning the suspension of compensation:

(a) Modify or set aside the order of consent before or after a request for hearing is filed;

(b) Order payment of compensation previously suspended when the director finds the suspension to have been made in error; and

(c) Reevaluate the necessity of continuing a suspension.

(11) Final orders. An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division.

Stat. Auth.: ORS 656.325, 656.704, 656.726(4)

Stats. Implemented: ORS 656.325, 656.704, 656.726(4)

Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94, Renumbered from 436-060-0085(1),(2),(4); WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2000, f. 12-22-00, cert. ef. 1-1-01; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0105

Suspension of Compensation for Insanitary or Injurious Practices, Refusal of Treatment or Failure to Participate in Rehabilitation; Reduction of Benefits

(1) General. The director may suspend compensation by order when the worker commits insanitary or injurious acts that imperil or delay recovery; refuses to submit to medical or surgical treatment reasonably required to promote recovery; or fails or refuses to participate in a physical rehabilitation program.

(a) The worker must have the opportunity to dispute the suspension of compensation before the director will issue an order.

(b) The worker is not entitled to compensation during or for the period of suspension.

(2) Notice to worker. The insurer must demand in writing the worker either immediately cease all actions which imperil or delay recovery or immediately begin to change the inappropriate behavior, and participate in activities needed to help the worker recover from the injury. Each time the insurer sends such a notice to the worker, the written demand must contain the following information, and a copy must be sent simultaneously to the worker's attorney and attending physician:

(a) A description of the unacceptable actions;

(b) Why such conduct is inappropriate, including the fact that the conduct is harmful or delays the worker's recovery, as appropriate;

(c) The date by which the inappropriate actions must stop, or the date by which compliance is expected, including what the worker must specifically do to comply; and,

(d) The following notice of the consequences should the worker fail to correct the problem, in prominent or bold face type:

"If you continue to do insanitary or injurious acts beyond the date in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we will request the suspension of your workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."

(3) Failure or refusal to accept medical treatment. For the purposes of this rule, failure or refusal to accept medical treatment means the worker fails or refuses to remain under a physician's or authorized nurse practitioner's care or abide by a treatment regimen. A treatment regimen includes, but is not limited to a prescribed diet, exercise program, medication or other activity prescribed by the physician or authorized nurse practitioner that is designed to help the worker reach maximum recovery and become medically stationary.

(4) Request for suspension of benefits. The insurer must verify whether the worker complied with the request for cooperation on the date specified in subsection (2)(c) of this rule. If the worker initially agrees to comply, or complies and then refuses or fails to continue doing so, the insurer is not required to send further notice before requesting suspension of compensation.

(a) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney, if any, by registered or certified mail or by personal service as for a summons.

(b) The request must include the following information:

(A) That the request for suspension is made in accordance with ORS 656.325 and OAR 436-060-0105;

(B) A description of the actions of the worker that prompted the request, including whether such actions continue;

(C) Any reasons offered by the worker to explain the behavior, or a statement that the worker has not provided any reasons, whichever is appropriate;

(D) How, when, and with whom the worker's failure or refusal was verified;

(E) A copy of the notice required in section (2) of this rule;

(F) Any other relevant information including, but not limited to; chart notes, surgical or physical therapy recommendations/prescriptions, and all recommendations from the attending physician or authorized nurse practitioner; and

(G) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter

Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."

(c) Any delay in obtaining confirmation or in requesting the suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual confirmation or the date the request is received by the division.

(d) If the director approves authorization of suspension of compensation:

(A) An order will be issued suspending compensation from a date established under subsection (2)(c) of this rule until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the director may require the worker to demonstrate cooperation before reinstating compensation;

(B) The insurer must make all reasonable efforts to assist the worker to reinstate benefits when the worker demonstrates the willingness to make such efforts;

(C) The insurer must monitor the claim to determine if and when the worker complies with the insurer's requests;

(i) When cooperation resumes, payment of compensation must resume effective the date cooperation was resumed;

(ii) If the worker makes no effort to reinstate benefits within 60 days of the mailing date of the suspension order, the insurer must close the claim under OAR 436-030-0034;

(D) The director may modify or set aside the suspension order before or after filing of a request for hearing;

(E) The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error;

(F) The director may reevaluate the necessity of continuing a suspension; and

(G) The order will become final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division.

(e) If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(5) Requests to reduce benefits. The director may reduce any benefits awarded the worker under ORS 656.268 when the worker has unreasonably failed to follow medical advice, or failed to participate in a physical rehabilitation or vocational assistance program prescribed for the worker under ORS chapter 656 and OAR chapter 436. Such benefits must be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate.

(a) When an insurer submits a request to reduce benefits under this section, the insurer must:

(A) Specify the basis for the request;

(B) Include all supporting documentation;

(C) Send a copy of the request, including the supporting documentation, to the worker and the worker's attorney, if any, by certified mail; and

(D) Include the following notice in prominent or bold face type:

"Notice to worker: If you think this request to reduce your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits."

(b) The director will make a decision on a request to reduce benefits and notify the parties of the decision. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the request to reduce benefits.

Stat. Auth.: ORS 656.325, 656.704, 656.726(4)

Stats. Implemented: ORS 656.325, 656.704, 656.726(4)

Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94, Renumbered from 436-060-0085(1),(2),(4),(5); WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2000, f. 12-22-00, cert. ef. 1-1-01; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0135

Injured Worker, Worker's Attorney Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

(1) Worker's responsibility to assist in investigation. A worker must submit to and fully cooperate with in person or telephone interviews and other formal or informal information gathering techniques reasonably requested by the insurer. Interviews may be recorded on audio or video by one or more of the parties if prior written notice is given of the intent to record an interview.

(2) Request to suspend compensation. The insurer may request for the director to suspend compensation by order when the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(14), under the following conditions:

(a) The insurer must notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements:

(A) The notice must be sent to the worker and copied to the worker's attorney, if any, and must contain the following:

(i) The date, time and place of the interview;

(ii) Any other reasonable investigation requirements;

(iii) That the interview, deposition, or any other investigation requirements are related to the worker's compensation claim; and

(iv) The following statement in prominent or bold face type:

"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you do not reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."

(B) If the insurer contracts with a third party to investigate the claim, the notice must be on the insurer's stationery and must meet the requirements of this section; and

(C) The worker must be given 14 days to cooperate with the notice.

(b) The director will consider requests to authorize suspension of benefits only after the worker has been given at least 14 days to cooperate with the notice under subsection (a) of this rule; and under the following conditions:

(A) The director will only consider requests in claims on which no acceptance or denial has been issued;

(B) The worker must have the opportunity to submit information disputing the insurer's request for suspension of compensation before the director will issue an order;

(C) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation;

(D) The insurer must make the request to suspend benefits to the director in writing, and must send a copy of the request, including all attachments, simultaneously to the worker and the worker's attorney, if any by registered or certified mail or by personal service;

(E) The insurer's request must include the following information sufficient to show the worker's failure to cooperate:

(i) That the insurer requests suspension of benefits under ORS 656.262(15) and this rule;

(ii) Documentation of the specific actions of the worker or worker's attorney that prompted the request;

(iii) Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons;

(iv) A copy of the notice required in section (2) of this rule; and

(v) All other pertinent information, including, but not limited to, a copy of the claim for a new or omitted condition when that is what the insurer is investigating;

(c) After receiving the insurer's request to suspend benefits, the director will notify all parties that:

(A) The worker's benefits will be suspended in five working days unless:

(i) The worker or the worker's attorney contacts the division by telephone or mails a letter documenting that the failure to cooperate was reasonable; or

(ii) The insurer notifies the division that the worker is now cooperating;

(B) The insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired;

(d) If the worker cooperates within five days of the director's notice under subsection (c), the insurer must notify the director immediately to withdraw the suspension request. Upon receiving the insurer's notification:

(A) The director will notify all the parties of the withdrawal; and

(B) The director may issue an order identifying the dates during which the insurer's obligation to accept or deny the claim was suspended;

(e) If the worker contacts the divisions and documents the failure to cooperate was reasonable within five days of the director's notice under subsection (c), the director will not suspend payment of compensation.

However, an order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended; and

(f) If the worker has not cooperated with the investigation, or documented that the failure to cooperate was reasonable within five days of the director's notice under subsection (c), the director will issue an order suspending all or part of the payment of compensation to the worker:

(A) The suspension of compensation will be effective from the fifth working day after the date of the director's notice under subsection (c), and will remain in effect until the worker cooperates with the investigation;

(B) If the worker begins cooperating with the investigation, the insurer must reinstate the worker's benefits immediately; or

(C) If the worker makes no effort to cooperate within 30 days of the date of the notice, the insurer may deny the claim under ORS 656.262(15) and OAR 436-060-0140(10).

(3) Request for penalty against worker's attorney. An insurer that believes that a worker's attorney's unwillingness or unavailability to participate in an interview is unreasonable may notify the director in writing and the director will consider assessment of a civil penalty against the attorney of not more than $1,000.

(a) The worker's attorney must have the opportunity to dispute the allegation before a penalty is assessed.

(b) A copy of the notice must be sent simultaneously to the worker and the worker's attorney. Notice to the division by the insurer must contain the following information:

(A) What specific actions of the attorney prompted the request;

(B) Any reasons given by the attorney for failing to participate in the interview; and

(C) A copy of the request for interview sent to the attorney.

(4) Failure to comply with this rule. Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request. Any delay in requesting suspension under section (2) of this rule may result in authorization being denied.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.262, 656.704, 656.726(4)
Hist.: WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 17-1996(Temp), f. 8-5-96, cert. ef. 8-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 6-2002(Temp), f. 4-22-02, cert. ef. 5-10-02 thru 11-5-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0137
Vocational Evaluations for Permanent Total Disability Benefits; and Suspension of Compensation

(1) Requests for vocational evaluations. A worker receiving permanent total disability benefits must attend a vocational evaluation reasonably requested by the insurer or the director.

(2) Allowed number of vocational evaluations. The insurer may request no more than three separate vocational evaluations without authorization from the director. Insurers that fail to obtain authorization from the director for additional vocational evaluations may be assessed a civil penalty.

(a) To request authorization the insurer must:

(A) Submit a written request for authorization that includes:

(i) The reasons for an additional vocational evaluation;

(ii) The conditions to be evaluated;

(iii) The dates, times, places, and purposes of previous evaluations;

(iv) Copies of previous vocational evaluation notification letters to the worker; and

(v) Any other information requested by the director;

(B) Provide a copy of the request to the worker and the worker's attorney, if any.

(b) The director will review the request and determine if additional information is needed.

(A) Upon receipt of a request for additional information from the director, the parties will have 14 days to respond.

(B) If the parties do not provide the requested information, the director will approve or disapprove the request for authorization based on available information.

(c) The director's decision approving or denying more than three vocational evaluations may be appealed to the Hearings Division within 60 days of the order.

(d) For purposes of determining the number of insurer required vocational evaluations, any evaluations scheduled but not completed are not counted as a statutory vocational evaluation.

(3) Notice to worker. The insurer must notify the worker of the evaluation at least 10 days before the date of evaluation.

(a) The notice sent for each evaluation, including evaluations that have been rescheduled, must contain the following:

(A) The name of the vocational assistance provider or facility;

(B) A statement of the specific purpose for the evaluation;

(C) The date, time and place of the evaluation;

(D) The first and last name of the attending physician or authorized nurse practitioner or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(E) If applicable, confirmation that the director has approved the evaluation;

(F) Notice to the worker that the reasonable cost of public transportation or use of a private vehicle will be reimbursed; when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed; a request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request; should an advance of costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance; and

(G) The following notice in prominent or bold face type:

"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you do not attend or do not cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or the Ombudsman for Injured Workers at 1-800-927-1271."

(b) The insurer may contract with a third party to schedule vocational evaluations. If the third party notifies the worker of a scheduled evaluation on behalf of the insurer, the third party must send the notice on the insurer's stationery and the notice must meet the requirements of this section.

(4) Reimbursements of costs. The insurer must pay the costs of the vocational evaluation and related services necessary to allow the worker to attend the evaluation, including a reasonable cost of public transportation or use of a private vehicle, and when necessary, a reasonable cost of child care, meals, lodging and other related services. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(5) Suspension of compensation. When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director, the director may suspend the worker's compensation by order, under the following conditions:

(a) The insurer must send the request for suspension to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service;

(b) The request must include the following information:

(A) That the insurer requests suspension of benefits under ORS 656.206 and OAR 436-060-0137;

(B) What specific actions of the worker prompted the request;

(C) The dates of any prior vocational evaluations the worker has attended and the names of the vocational assistance provider or facilities, or a statement that there have been no prior evaluations, whichever is appropriate;

(D) A copy of any approvals given by the director for more than three vocational evaluations, or a statement that no approval was necessary, whichever is appropriate;

(E) Any reasons given by the worker for failing to attend, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(F) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the vocational evaluation received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;

(G) A copy of the letter required in section (3) of this rule and a copy of any written verification received under paragraph (F) of this subsection;

(H) Any other information that supports the request; and

(I) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits."

(c) If the director suspends compensation:

(A) The suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the director determines is appropriate until the date the worker attends the evaluation;

(B) The worker is not entitled to compensation during or for the period of suspension;

(C) The insurer must assist the worker to meet requirements necessary for the resumption of compensation payments. When the worker has attended the vocational evaluation, the insurer must verify the worker's participation and resume compensation effective the date of the worker's compliance;

(D) The director may modify or set aside the suspension order before or after filing of a request for hearing;

(E) The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error; and

(F) The director may reevaluate the necessity of continuing a suspension;

(d) If the insurer fails to comply with this rule, the director may deny the request for suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified; and

(e) A suspension order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.206
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0140
Acceptance or Denial of a Claim

(1) Claim investigations. The insurer is required to conduct a "reasonable" investigation based on all available information in determining whether to deny a claim.

(a) A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(b) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

(2) Notice to worker. The insurer must give the worker written notice of acceptance or denial of a claim within the following time frames:

(a) For claims with a date of injury before January 1, 2002, within 90 days of:

(A) The employer's notice or knowledge of an initial claim;

(B) The insurer's receipt of a Form 827 signed by the worker or the worker's attorney, and the worker's attending physician indicating an aggravation claim; or

(C) Written notice of a new medical condition claim;

(b) For claims with a date of injury on or after January 1, 2002, within 60 days after:

(A) The employer's notice or knowledge of an initial claim

(B) The insurer's receipt of a Form 827 signed by the worker or the worker's attorney and the worker's attending physician indicating an aggravation claim; or

(C) Written notice of a new medical or omitted condition claim; or

(c) For claims with any date of injury, if the worker challenges the location of an independent medical examination under OAR 436-010-0265 and the challenge is upheld, within 90 days after the employer's notice or knowledge of the claim.

(3) Penalty for untimely acceptance and denials. The director may assess a penalty under OAR 436-060-0200 against any insurer delinquent in accepting or denying a claim beyond the time frame required under section (2) of this rule

(4) Notice of acceptance. A notice of acceptance must comply with ORS 656.262(6)(b) and OAR chapter 438-. It must include a current mailing date, be addressed to the worker, be copied to the worker's attorney, if any, and the worker's attending physician, and describe to the worker:

(a) What conditions are compensable;

(b) Whether the claim is disabling or nondisabling;

(c) The Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;

(d) The employment reinstatement rights and responsibilities under ORS chapter 659A;

(e) Assistance available to employers from the Reemployment Assistance Program under ORS 656.622;

(f) That claim related expenses paid by the worker must be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses. The worker must be advised of the two year time limitation to request reimbursement as provided in OAR 436-009-0025 and that reimbursement of expenses may be subject to a maximum established rate;

(g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient; and

(h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.

(5) Notice of acceptance, fatal claims. In the case of a fatal claim, the notice must be addressed "to the estate of" the worker and the requirements of subsection (4)(a) through (h) of this rule must not be included.

(6) Initial, updated, and modified notices of acceptance.

(a) The first acceptance issued on the claim must contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance must contain all accepted conditions at the time of the notice.

(b) When an insurer closes a claim, it must issue an "Updated Notice of Acceptance at Closure" under OAR 436-030-0015. To correct an omission or error in an "Updated Notice of Acceptance at Closure", under OAR 436-030-0015(1)(c)(D), the insurer must add the word "Corrected" to the notice.

(c) An insurer must issue a "Modified Notice of Acceptance" (MNOA) when the insurer:

(A) Accepts a new or omitted condition on a nondisabling claim, while a disabling claim is open or after claim closure;

(B) Accepts an aggravation claim;

(C) Changes the disabling status of the claim; or

(D) Amends a notice of acceptance, including correcting a clerical error, except for an error or omission on an "Updated Notice of Acceptance at Closure."

(7) Acceptance of new or omitted conditions. When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267. When a claim is reopened, the notice of acceptance must specify the conditions for which the claim is being reopened.

(8) Notice of denial to worker. A notice of denial must comply with OAR chapter 438, and must:

(a) Specify the factual and legal reasons for the denial, including the worker's right to request a worker requested medical examination and a specific statement indicating if the denial was based in whole or part on an independent medical examination, under ORS 656.325, and one of the following statements, as appropriate:

(A) "Your attending physician agreed with the independent medical examination report";

(B) "Your attending physician did not agree with the independent medical examination report"; or

(C) "Your attending physician has not commented on the independent medical examination report";

(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283;

(c) If the denial is under ORS 656.262(15), it must inform the worker that a hearing may occur sooner if the worker requests an expedited hearing under ORS 656.291; and

(d) If paragraph (8)(a)(B) of this rule applies, the denial notice must also include the division's website address and toll free phone number for the worker's use in obtaining a brochure about the worker requested medical examination.

(9) Notice of denial to provider of medical services and health insurance. The insurer must send notice of the denial to each provider of medical services, and health insurance as defined under ORS 731.162, when compensability of any portion of a claim for medical services is denied when any of the following applies:

(a) The denial is sent to the worker;

(b) Within 14 days of receipt of any billings from medical providers not previously notified of the denial. The notice must advise the medical provider of the status of the denial; or

(c) Within 60 days of the date when compensability of the claim has been finally determined or when disposition of the claim has been made.

The notification must include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

(10) Payment of compensation. The insurer must pay compensation due under ORS 656.262 and 656.273 until the claim is denied, except where there is an issue concerning the timely filing of a notice of accident as provided in ORS 656.265(4). The employer may elect to pay compensation under this section in lieu of the insurer doing so. The insurer must report to the division payments of compensation made by the employer as if the insurer had made the payment.

(11) Medical benefits and funeral expenses. Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include:

(a) The costs of medical benefits; or

(b) The cost of final disposition of the body or funeral expenses.

Stat. Auth.: ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.262, 656.325, 656.726(4)

Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0305, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 12-1992, f. 6-12-92, cert. ef. 7-1-92; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 17-1996(Temp), f. 8-5-96, cert. ef. 8-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0147

Worker Requested Medical Examination

(1) Eligibility. The director will determine the worker's eligibility for a worker requested medical examination under ORS 656.325(1). The worker is eligible for an exam if:

(a) The worker has made a timely request for a Workers' Compensation Board hearing on a denial of compensability as required by ORS 656.319(1)(a);

(b) The denial was based on one or more independent medical examination reports; and

(c) The attending physician or authorized nurse practitioner did not concur with the report or reports.

(2) Request for exam. The worker must submit a request for the exam to the division. A copy of the request must be sent simultaneously to the insurer. The request must include:

(a) The name, address, and claim identifying information of the worker;

(b) A list of physicians, including names and addresses, who have previously provided medical services to the worker on the claim, or who have previously provided medical services to the worker related to the claimed conditions;

(c) The date the worker requested a hearing and a copy of the hearing request;

(d) A copy of the insurer's denial letter; and

(e) Documents that demonstrate that the attending physician or authorized nurse practitioner did not concur with the independent medical examination report or reports.

(3) Required documentation. The insurer must mail to the director no later than the 14th day following the insurer's receipt of the worker's request, the names and addresses of all physicians or nurse practitioners who have:

(a) Acted as the worker's attending physician or authorized nurse practitioner;

(b) Provided medical consultations or treatment to the worker;

(c) Examined the worker at an independent medical examination requested by the insurer under ORS 656.325; or

(d) Reviewed the worker's medical records on the claim..

(4) Penalty for failure to provide documentation. Failure to provide the required documentation described in section (3) of this rule in a timely manner may subject the insurer to civil penalties under OAR 436-060-0200.

(5) Selection of physicians. The director will notify all parties in writing of the physician selected, or will provide the worker or the worker's attorney a list of appropriate physicians. If the director provides a list of physicians, the following applies:

(a) The worker's or the worker's attorney's response must be in writing, signed, and delivered to the director within 14 days of the mailing date of the list;

(b) The worker or the worker's attorney may eliminate the name of one physician from the list;

(c) If the worker or the worker's attorney does not respond as provided in this section, the director will select a physician; and

(d) The director will notify the parties in writing of the physician selected.

(6) Scheduling the exam. The worker or the worker's attorney must schedule the exam with the selected physician and notify the insurer and the Workers' Compensation Board of the scheduled exam date within 14 days of the notification date in section (5) of this rule. An unrepresented worker may consult with the Ombudsman for Injured Workers for assistance.

(7) Required medical records. The insurer must send the physician the worker's complete medical and diagnostic record on the claim and the original questions asked of the independent medical examination physicians no later than 14 days before the date of the scheduled exam. If the diagnostic records are not in the insurer's possession, the insurer must request that the medical provider send the diagnostic records to the selected physician at least 14 days before the scheduled exam.

(8) Exam questions. The worker, or the worker's attorney, must communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days before the scheduled date of the exam. An unrepresented worker may consult with the Ombudsman for Injured Workers for assistance.

(9) Physician's response. Upon completion of the exam the physician must address the original independent medical examination questions and the questions from the worker or the worker's attorney under section (8) of this rule and send the report to the worker's attorney, if any, or the worker, and the insurer within 14 days.

(10) Payment of physician. The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Medical services to workers must be delivered in accordance with OAR 436-010.

(11) Failure to attend exam. If the worker does not attend the scheduled worker requested medical exam, the insurer must pay the physician for the missed exam under OAR 436-009-0010(13). The insurer is not required to pay for another exam unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.

(12) Reimbursement for services. The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.325(1)

Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0150

Timely Payment of Compensation

(1) General. Benefits are considered paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail, or when funds are transferred to a financial institution for deposit in the worker's or beneficiary's account by approved electronic equivalent. Payments due on a weekend or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day before, or the first working day after, the weekend or legal holiday. Subsequent payments may revert back to the payment schedule in place before the weekend or legal holiday.

(2) Holidays. For the purpose of this rule, legal holidays in the State of Oregon are:

(a) Each Sunday;

(b) New Year's Day on January 1;

(c) Martin Luther King, Jr.'s Birthday on the third Monday in January;

(d) Presidents Day, for the purpose of commemorating Presidents Washington and Lincoln, on the third Monday in February;

(e) Memorial Day on the last Monday in May;

(f) Independence Day on July 4;

(g) Labor Day on the first Monday in September;

(h) Veterans Day on November 11;

(i) Thanksgiving Day on the fourth Thursday in November;

(j) Christmas Day on December 25.

(k) Each time a holiday, other than Sunday, falls on Sunday, the succeeding Monday;

(l) Each time a holiday falls on Saturday, the preceding Friday; and

(m) Every day appointed by the Governor as a legal holiday and every day appointed by the President of the United States as a day of mourning, rejoicing or other special observance only when the Governor also appoints that day as a holiday.

(3) Withheld compensation. Compensation withheld under ORS 656.268(13) and (14), and ORS 656.596(2), will not be considered late if

the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

(4) Timely payment of temporary disability. First payment of temporary disability compensation must be timely. The director may assess a penalty under OAR 436-060-0200 against an insurer that does not make the first payment of temporary disability under the time frames of this section, or does not accurately report timeliness of first payment information.

(a) The first payment of temporary disability benefits must be made no later than the 14th day after:

(A) The date of the employer's notice or knowledge of the claim and of the worker's disability, if the attending physician or authorized nurse practitioner has authorized temporary disability compensation. Temporary disability accrued before the date of the employer's notice or knowledge of the claim is due within 14 days of claim acceptance;

(B) The date the attending physician or authorized nurse practitioner authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim and of the worker's disability;

(C) The start of authorized vocational training under ORS 656.268(10), if the insurer has previously closed the claim;

(D) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;

(E) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of temporary disability. If the insurer has appealed a reconsideration order, the appeal stays payment of temporary disability benefits except those that accrue from the date of the order, under ORS 656.313;

(F) The date of a notice of claim closure issued by the insurer that finds the worker entitled to temporary disability;

(G) The date a notice of closure is set aside by a reconsideration order;

(H) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the signature date, and from the courts, it is the date of the appellate judgment;

(I) The date the director refers a claim to the insurer for processing under ORS 656.029;

(J) The date the director refers a noncomplying employer claim to an assigned claims agent under ORS 656.054;

(K) The date a claim disposition agreement is disapproved by the Worker's Compensation Board or administrative law judge, if temporary disability benefits are otherwise due;

(L) The date the director designates a paying agent under ORS 656.307;

(M) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; or

(N) The date an insurer voluntarily rescinds a denial of a disabling claim.

(b) Subsequent payments of temporary disability benefits must:

(A) Be made at least once each 14 days, unless the employer is making payments under OAR 436-060-0020(1) and the payments are made concurrently with the payroll schedule of the employer; and

(B) Include all benefits due for the period ending no more than seven days before the payment date;

(5) Timely payment of permanent disability.

(a) The first payment of permanent disability must be paid no later than the 30th day after:

(A) The date of a notice of claim closure issued by the insurer;

(B) The date of any litigation order that orders payment of permanent total disability. Permanent total disability benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the signature date, and from the courts, it is the date of the appellate judgment;

(C) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of compensation for permanent disability;

(D) The date any litigation order authorizing permanent partial disability becomes final;

(E) The date a claim disposition agreement is disapproved by the Workers' Compensation Board or administrative law judge, if permanent disability benefits are otherwise due; or

(F) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(10) and OAR 436-060-0040(3).

(b) Subsequent payments of permanent disability must be made on a regular and predictable monthly schedule.

(A) The insurer may adjust the monthly payment schedule, but must inform the worker or beneficiary before making the adjustment.

(B) No payment period may exceed one month without the director's approval.

(6) Timely payment of fatal benefits.

(a) The first payment of fatal benefits under ORS 656.204 must be paid no later than the 30th day after:

(A) The date of a notice of acceptance issued by the insurer; or

(B) The date of any litigation order which orders fatal benefits. Fatal benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board is the signature date, and from the courts, it is the date of the appellate judgment.

(b) Subsequent payments of fatal benefits must be made on a regular and predictable monthly schedule.

(A) The insurer may adjust the monthly payment schedule, but must inform the beneficiary before making the adjustment.

(B) No payment period may exceed one month without the director's approval.

(7) Notice to worker or beneficiary regarding payments. The insurer must provide an explanation in writing to the worker or beneficiary when the benefit amount, time period covered, or payment schedule changes, and must:

(a) Notify the worker or beneficiary in writing of the specific purpose and the time period covered by each payment of temporary disability benefits; and

(b) Notify the worker or beneficiary in writing of the specific purpose of the payment, the schedule of future payments, and the time period each payment will cover with the first payment of permanent disability or fatal benefits. The insurer is not required to provide an explanation in writing with each subsequent permanent disability or fatal benefit payment.

(8) Maintenance of records. The insurer must maintain records of compensation paid for each claim in which benefits are due and payable.

(9) Request for reimbursement. If the worker submits a request for reimbursement of multiple items and full reimbursement is not made, the insurer must provide specific reasons for non-payment or reduction of each item.

(10) Claim disposition agreements. Any amounts due under a claim disposition agreement must be paid no later than the 14th day after the Workers' Compensation Board or administrative law judge provides notice of its approval under OAR 438-009-0028, unless otherwise stated in the agreement.

(11) Claims under other jurisdictions. When a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon:

(a) The worker is entitled to the full amount of compensation due under Oregon law;

(b) The total amount paid or awarded under the other jurisdiction's law must be credited against the compensation due under Oregon law;

(c) If Oregon compensation is more than the compensation paid or awarded under the other jurisdiction's law, or compensation paid the worker under another law is recovered from the worker, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law;

(d) Upon learning that the worker has a claim under the jurisdiction of another workers' compensation law, the insurer must request written documentation of the amount paid or awarded to the worker; and

(e) Payment under this section is due within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.126, 656.262(4), 656.268(10), 656.273, 656.278, 656.289, 656.307, 656.313

Hist.: WCB 9-1966, f. & ef. 11-14-66; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0310, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD

8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0153
Electronic Payment of Compensation

(1) General. An insurer may pay benefits through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the worker voluntarily consents.

(a) The worker's consent must be obtained before initiating electronic payments.

(b)The consent may be written or verbal. The insurer must provide the worker a written confirmation when consent is obtained verbally.

(c) The worker may discontinue receiving electronic payments by notifying the insurer in writing.

(d) An employer making payments under OAR 436-060-0020(1) may assume the worker consents to having benefits paid through a direct deposit system if that is the method the employer usually uses to pay the worker's wages.

(2) Cardholder agreement for ATM or debit cards. The worker must receive a copy of the cardholder agreement outlining the terms and conditions under which an automated teller machine card or debit card has been issued before or at the time the initial electronic payment is made.

(3) Instrument of payment. The instrument of payment must be negotiable and payable to the worker for the full amount of the benefit paid, without cost to the worker.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.262(4), 84.013
Hist.: WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0155
Penalty to Worker for Untimely Processing

(1) General. If the insurer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim:

(a) The director may require the insurer to pay:

(A) A penalty of up to 25 percent of the amounts then due to the worker, determined by the matrix attached to these rules in Appendix "B" and the following:

(i) When there are no "amounts then due" upon which to assess a penalty, no penalty will be issued under this rule; and

(ii) If the worker has not provided sufficient information to assess a penalty, the director may assess a civil penalty under OAR 436-060-0200 instead; and

(B) A fee to the worker's attorney under ORS 656.262(11) and OAR 436-001-0420.

(b) For the purpose of this rule, and the matrix attached to these rules in Appendix "B," a "violation" is:

(A) The late payment or the nonpayment of any single payment due;

(B) A continuous underpayment, such as with yearly cost of living increases for temporary disability compensation. In the case of a continuous underpayment, all prior underpayments will be considered as one violation, regardless of when the first underpayment occurred; or

(C) The late issuance of an acceptance or denial notice under OAR 436-060-0140(2).

(2) Requests for penalties and attorney fees. Requests for penalties and attorney fees under this rule must:

(a) Be made in writing;

(b) State, in the request, what benefits have been delayed or remain unpaid; and

(c) Be mailed or delivered to the division within 180 days of the date of the alleged violation. For the purposed of this rule, the date of the alleged violation is:

(A) For the late payment or nonpayment of any single payments, the date payment was due;

(B) For a continuous underpayment, the date of the last underpayment; or

(C) For a late issuance of an acceptance or denial notice, the date the notice was due under OAR 436-060-0140(2).

(3) Required response from the insurer. When notified by the director that additional amounts may be due the worker as a penalty under this rule:

(a) The insurer must respond in writing to the division:

(A) The response must include a reason for the delay, and any additional information or documentation requested by the director;

(B) The response must be mailed or delivered to the division within 21 days of the mailing date of the director's inquiry letter; and

(C) Copies of the response, including any attachments, must be simultaneously sent to the worker and the worker's attorney, if any;

(b) If the insurer fails to meet the requirements of this section, the director may assess an additional civil penalty under OAR 436-060-0200.

(4) Jurisdiction over proceedings. The director has exclusive jurisdiction when the assessment and payment of penalties and attorney fees described in ORS 656.262(11) are the only issues of the proceedings between the parties. The director will not issue an order assessing a penalty or attorney fee under this rule when the same parties have initiated proceedings before the Hearings Division.

(a) If the director receives a request for penalties and attorney fees under this rule, and is aware of proceedings between the parties before the Hearings Division, the director will refer the request to the Hearings Division.

(b) If the director has not been made aware of the proceeding before the Hearings Division and issues a penalty order that becomes final, the director's penalty will stand.

(5) Timely payment of penalties. Penalties ordered under this rule must be paid to the worker no later than the 30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty will be due within 14 days of the date the order upholding the penalty becomes final. If the insurer does not pay penalties in a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.

(6) Dispute resolution. Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, attorney fees or costs, or unreasonable delay in acceptance or denial of a claim may be resolved by the parties.

(a) In cases where the director has exclusive jurisdiction under section (4) of this rule, and the violations occurred within the last 180 days as described in subsection (2)(c) of this rule, then the parties must submit a stipulation to the division for approval. The stipulation must specify:

(A) The benefits, attorney fees, or costs delayed and the amounts;

(B) The time periods involved;

(C) If applicable, the name of the medical providers and the dates of services relating to medical bills;

(D) The amount of the penalty not to exceed 25 percent of the amount of compensation delayed; and

(E) The attorney fees, if applicable.

(b) Any other agreements between the parties to pay a penalty or attorney fee must have a stipulation approved by the director to be acknowledged as a violation as it applies to the matrix in Appendix "B" of these rules.

(c) Payment of a penalty due under this section is due within 14 days after the date the director approves the stipulation, unless otherwise stated in the stipulation. If the insurer does not pay penalties in a timely manner the insurer will be subject to civil penalties under OAR 436-060-0200.

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 656.262(11), 656.704, 656.726(4), 656.745
Stats. Implemented: ORS 656.262(11), 656.704
Hist.: WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0160
Use of Sight Draft to Pay Compensation Prohibited

Insurers may not use a sight draft to pay any benefits or payments due a worker or beneficiary under ORS chapter 656.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist.: WCB 18-1975, f. 12-19-75, ef. 1-1-76; WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0315, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0170
Recovery of Overpayment of Benefits

(1) Benefits paid a worker. An insurer may only recover overpayment of benefits paid to a worker as specified by ORS 656.268(14), unless authority is granted by an administrative law judge or the Workers' Compensation Board.

(2) Benefits due a worker. An insurer may recover an overpayment from any benefits currently due on any claim the worker has with that insurer. The insurer must explain in writing the reason, the amount, and the

method of recovery to the worker and the worker's attorney, if any, or to the worker's beneficiaries.

(3) Permanent partial disability offsets. When overpaid benefits are offset against monthly permanent partial disability award payments, the insurer must recover the benefits from the total amount of the award. The insurer must pay out the remainder of the award at 4.35 times the temporary total disability rate, or at least $108.75, starting with the first month's payment.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.268(13)(14)
Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; WCD 3-1984(Admin), f. & ef. 4-4-84; Renumbered from 436-054-0320, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0180
Designation and Responsibility of a Paying Agent

(1) For the purpose of this rule:

(a) "Compensable injury" means an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.

(b) "Exposure" means a specific incident or period during which a compensable injury may have occurred.

(c) "Responsibility" means liability under the law for the acceptance and processing of a compensable claim.

(2) General. The director will designate by order which insurer must pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:

(a) Which subject employer is the true employer of the worker;

(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to the worker;

(c) Which of two or more employers or their insurers is responsible for paying compensation for one or more on-the-job injuries or occupational diseases; or

(d) Which of two or more employers is responsible when there is joint employment.

(3) Own motion claims. With the consent of the Workers' Compensation Board, own motion claims under ORS 656.278(1) are subject to this rule.

(4) Determination of compensability. Upon learning of any of the issues described in section (2) of this rule, the insurer must expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable.

(a) For the purposes of this rule, insurers identified in a potential responsibility dispute under ORS 656.307 must, upon request, share claim related medical reports and other information pertinent to the injury without charge in order to expedite claim processing.

(b) The act of the worker applying for compensation benefits from any employer identified as a party to a responsibility dispute constitutes authorization for the involved insurers to share the pertinent information in accordance with the criteria and restrictions provided in OAR 436-060-0017 and 436-010-0240.

(c) Copies of claims documents must be mailed under the time frames established in OAR 436-060-0017(4).

(d) An insurer that shares information under this rule bears no legal liability for disclosure of the information.

(5) Notification of affected insurers. Upon learning of any of the issues described in section (2) of this rule, the insurer must immediately notify any other affected insurers of the situation. Such notice must identify the compensable injury and include a copy of all medical reports and other information pertinent to the injury. The notice must identify each period of exposure that the insurer believes responsible for the compensable injury by the following:

(a) Name of employer;

(b) Name of insurer;

(c) Specific date of injury or period of exposure; and

(d) Claim number, if assigned.

(6) Request for designation of a paying agent. Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer must request designation of a paying agent from the director in writing and mail a copy of the request to the worker and the worker's attorney, if any.

(a) The insurer may not attach the request to, or include the request in, any form or report the insurer is required to submit under OAR 436-060-0011 or in the denial letter to the worker required by OAR 436-060-0140.

(b) The request, or agreement to designation of a paying agent, is not an admission that the insurer is responsible for the compensable injury; it is solely an assertion that the injury is compensable against a subject Oregon employer.

(c) The insurer's written request must contain the following information:

(A) Identification of the compensable injuries or occupational diseases;

(B) That the insurer is requesting designation of a paying agent under ORS 656.307;

(C) That the insurer acknowledges the claim is otherwise compensable;

(D) That responsibility is the only issue;

(E) Identification of the specific claims or exposures involved by:

(i) Employer;

(ii) Insurer;

(iii) Date of injury or specific period of exposure; and

(iv) Claim number, if assigned;

(F) Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties; and

(G) Confirmation the worker has been advised of the actions being taken on the worker's claim.

(d) The director will not designate a paying agent when:

(A) It has not been determined if the injury is compensable against a subject Oregon employer;

(B) An insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim; or

(C) The 60 day appeal period of a denial expired and:

(i) No request for hearing had been received by the Board; or

(ii) No request for a designation of paying agent order had been received by the director.

(7) Failure to respond to request for clarification. When notified by the director that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer must provide written clarification to the director, the worker, the other insurers involved and other interested parties within 21 days of the mailing date of the notification. If an insurer fails to respond timely or provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty under OAR 436-060-0200.

(8) Insurer responsibilities. Insurers receiving notice from the director of a worker's request for designation of a paying agent must immediately process the request in accordance with sections (4) through (6) of this rule.

(9) Factors for designation. Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the director will issue an order designating a paying agent under ORS 656.307. The director will designate the insurer with the lowest compensation considering the following factors:

(a) The claim with the lowest temporary total disability rate;

(b) If the temporary total disability rates and the rates per degree of permanent disability are the same, the earliest claim;

(c) If there is no temporary disability or the temporary total disability rates are the same, but the rates per degree of permanent disability are different, the claim with the lowest rate per degree of permanent disability;

(d) If one or more claims have disposed of benefits in accordance with ORS 656.236(1), the claim providing the lowest compensation not released by the claim disposition agreement;

(e) If one claim is under own motion jurisdiction, that claim, even if it is not the claim with the lowest temporary total disability rate; and

(f) If more than one claim is under own motion jurisdiction, the own motion claim with the lowest temporary total disability rate.

(10) Referral to the Worker's Compensation Board. By copy of its order, the director will refer the matter to the Workers' Compensation Board to set a proceeding under ORS 656.307 to determine which insurer is responsible for paying benefits to the worker.

(11) Responsibilities of designated paying agent. The designated paying agent must process the claim as an accepted claim through claim closure under OAR 436-030-0015 unless it is relieved of the responsibility by an order of the administrative law judge or resolution through mediation or arbitration under ORS 656.307(6).

(a) The parties to an order under this section may not settle any part of a claim under ORS 656.236 or 656.289, except to resolve the issue of

responsibility, unless prior approval and agreement is obtained from all potential responsible insurers.

(b) Resolution of a dispute by mediation or arbitration by a private party cannot obligate the Consumer and Business Services Fund without the director's prior approval.

(c) The Consumer and Business Services Fund is not obligated when one party declines to participate in a legitimate settlement conference under an ORS 656.307 order.

(d) Compensation paid under the order must include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due must be for periods subsequent to periods of disability already paid by any insurer.

(12) Change in compensability or claims status. After a paying agent is designated, if any of the insurers determine compensability may be an issue at hearing, the insurer must notify the director.

(a) Any insurer must notify the director and all parties to the order of any change in claim acceptance status after the designation of a paying agent.

(b) When the director receives notification of a change in the acceptance of a claim or notification that compensability is an issue after designation of a paying agent, the director will order termination of any further benefits due from the original order designating a paying agent.

Stat. Auth.: ORS 656.307, 656.726(4), 656.745
Stats. Implemented: ORS 656.307, 656.308
Hist.: WCD 1-1980(Admin), f & ef. 1-11-80; WCD 5-1980(Admin)(Temp), f & ef. 4-29-80; WCD 7-1980(Admin), f. 9-5-80, ef. 10-1-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0332, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0190
Monetary Adjustments among Parties and Department of Consumer and Business Services

(1) General. An order of the director under ORS 656.307 and OAR 436-060-0180 applies only to the period before the order of the administrative law judge determining the responsible paying party. Payment of compensation made after the order may not be recovered from the Consumer and Business Services Fund, unless the director concludes payment was made before the administrative law judge's order was received by the paying agent designated under OAR 436-060-0180. After the administrative law judge's order, any necessary monetary adjustments must be made under OAR 436-060-0195.

(2) Determination of benefits paid. When all litigation on the issue of responsibility is final, the insurer ultimately held to be responsible must, before paying any compensation, contact any nonresponsible insurer to determine what compensation has already been paid. When contacted by the responsible insurer, the nonresponsible insurer must provide the requested information necessary for the responsible insurer to make a timely payment to the worker, medical providers or others, but in any case no later than 20 days after the date of contact. Failure to respond to the responsible insurer's inquiry in a timely manner may result in non-reimbursement otherwise due from the responsible insurer or from the Consumer and Business Services Fund.

(3) Reimbursement of nonresponsible insurers. The responsible insurer must reimburse any nonresponsible insurers for compensation the nonresponsible insurer paid that the responsible insurer is responsible for, but has not already paid, within 30 days of receiving enough information to determine the benefits paid and the relationship to the conditions involved. Any balance remaining due the worker, medical providers or others must be paid in a timely manner under OAR 436-009 and 436-060-0150. Payment of compensation that results in duplicate payment to the worker, medical providers or others as a result of failing to contact the nonresponsible insurer does not release the responsible insurer from the requirement to reimburse any nonresponsible insurers for its costs.

(4) Direction of unresolved adjustments. The director may direct any necessary monetary adjustment between the parties that is not otherwise ordered by the administrative law judge or voluntarily resolved by the parties. The director will not order an insurer to pay compensation above that required by law, as it relates to the insurer's claim, except in the situation described in section (3) of this rule. Any insurer that fails to make monetary adjustments within 30 days of an order by the director may be subject to civil penalties under OAR 436-060-0200. Only compensation paid as a result of an order by the director under OAR 436-060-0180 and consistent with this rule is recoverable from the Consumer and Business Services Fund when such compensation is not reimbursed to the nonresponsible insurer by the responsible insurer.

(5) Unnecessary costs. When the director determines improper or untimely claim processing by the designated paying agent has resulted in unnecessary costs, the director may deny reimbursement from the responsible insurer and the Consumer and Business Services Fund.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.307(3)
Hist.: WCB 5-1970, f. 6-3-70, ef. 6-25-70; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 5-1980(Admin)(Temp), f. & ef. 4-29-80; WCD 7-1980(Admin), f. 9-5-80, ef. 10-1-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0334, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0195
Miscellaneous Monetary Adjustments Among Insurers

(1) General. The director may order monetary adjustments between insurers when a worker has a right to compensation, but there is a dispute between insurers that does not fall under the director's authority in ORS 656.307 and OAR 436-060-0190.

(a) When any litigation on the issues in question is final, insurers must make any necessary monetary adjustments between themselves, consistent with the determination of coverage for compensation paid to the worker, medical providers, and others for which they are responsible, within 30 days of receiving enough information to determine the benefits paid and the relationship to the conditions involved.

(b) Any balance due after making such adjustments must be paid in a timely manner to the worker, medical providers and other parties under OAR 436-009 and 436-060-0150.

(c) Any failure to obtain reimbursement from an insurer under this rule is not recoverable from the Consumer and Business Services Fund.

(2) Obligation to process claims. The director may direct any necessary monetary adjustment between parties, but will not order an insurer to pay compensation above that required by law, as it relates to the insurer's claim, except when an insurer unduly compensates a worker while having knowledge such compensation has already been paid by another insurer. However, each insurer has its own independent obligation to process its claim and pay compensation due until the claim is either accepted or denied. When notified by the director that a dispute over monetary adjustment exists the insurer must provide a written response to questions or issues raised, including supporting documentation, to the division, the other insurers involved and other interested parties within 21 days of the mailing date of the notification.

(3) Failure to make adjustments. Failure to respond to the director's inquiries or make monetary adjustments within 30 days of an order by the director will subject the insurer to civil penalties under OAR 436-060-0200.

(4) Unnecessary costs. When the director determines improper or untimely claim processing by an insurer resulted in unnecessary costs, the director may deny monetary adjustment between the insurers.

Stat. Auth.: ORS 656.704, 656.726(4), 656.745
Stats. Implemented: ORS 656.704, 656.726(4)
Hist.: WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02 ; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0200
Assessment of Civil Penalties

(1) Penalties for inducing failure to report claims. The director may assess a civil penalty against an employer or insurer that intentionally or repeatedly induces workers to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades workers to accept less than the compensation due or makes it necessary for workers to resort to proceedings against the employer to secure compensation due.

(a) A penalty under this section will only be assessed after all litigation on the matter has become final by operation of the law.

(b) For the purpose of this section:

(A) "Intentionally" means the employer or insurer acted with a conscious objective to cause any result described in ORS 656.745(1) or to engage in the conduct described in that section; and

(B) "Repeatedly" means more than once in any twelve month period.

(2) Penalties for failure to comply with statutes, rules, and orders. The director may assess a civil penalty against an employer or insurer that does not comply with the rules and orders of the director regarding reports or other requirements necessary to carry out the purposes of ORS chapter 656. Except as provided in ORS 656.780, the director may assess a civil penalty against a service company only for claims processing violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.

(3) Penalties for failure to meet time frame requirements. The director may assess a civil penalty of up to $2,000 against an employer or insurer that does not meet the time frame requirements in OAR 436-060-0010, 436-060-0011, 436-060-0017, 436-060-0018, 436-060-0030, 436-060-0060, 436-060-0140, 436-060-0147, 436-060-0155 and 436-060-0180. The director may assess a civil penalty of up to $2,000 to a service company failing to meet the time frame requirements, only for violations identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer, or service company identified in an annual audit.

(4) Penalties for use of sight draft to pay compensation. The director may assess a civil penalty of up to $2,000 against an insurer that willfully violates OAR 436-060-0160.

(5) Penalties for inaccurate reporting of first payment timeliness. The director may assess a civil penalty of $500 against an insurer that does not accurately report timeliness of first payment information to the division, plus $50 for each violation, up to $10,000 in the aggregate for all violations within any three month period. The director may assess this civil penalty to the service company processing the insurer's claims if the violations were identified in the director's annual audits of claims processing performance. The director may assess only one penalty for each separate violation by an insurer or service company identified in an annual audit. For the purposes of this section, a violation consists of each situation in which a first payment was reported to have been made timely, but was found upon audit to have actually been late.

(6) Penalties for failure to comply with claims processing requirements. Notwithstanding section (3) of this rule, the director may assess civil penalties of up to $2,000 against an employer, insurer, or service company for each violation of the claims processing requirements of ORS chapter 656, OAR chapter 436 and orders of the director.

(a) Penalties assessed for all violations will not exceed $10,000 in the aggregate within any three month period.

(b) For the purpose of this section, the statutory claims processing requirements include but are not limited to, ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, and 656.331.

(7) Penalties for misrepresentation to obtain claims records. The director may assess a civil penalty of $1,000 against any employer or insurer that misrepresents itself in any manner to obtain workers' compensation claims records from the director, or that uses such records in a manner contrary to these rules. In addition the director may suspend or revoke:

(a) An employer's or insurer's access to workers' compensation claims records for such time as the director may determine; or

(b) Any other person's access to workers' compensation claims records if the director determines they have misrepresented themselves or used records in a manner contrary to these rules.

(8) Performance audits. Insurers will be subject to periodic performance audits. Civil penalties may be issued for each area where the insurer's performance falls below the acceptable standards set forth in the rules and orders of the director.

(9) Considerations for assessing penalties. In arriving at the amount of penalty under this rule, the director may consider, but is not limited to:

(a) The ratio of the volume of violations to the volume of claims reported;

(b) The ratio of the volume of violations to the average volume of violations for all insurers; and

(c) Prior performance in meeting the requirements outlined in this section.

(10) Penalty to worker's attorney for failure to cooperate with insurer's investigation. The director may assess a civil penalty not to exceed $1,000 against a worker's attorney that is unreasonably unwilling or unavailable to participate in an insurer's interview as required by ORS 656.262(14).

[ED. NOTE: Appendices & Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.704, 656.726(4)

Stats. Implemented: ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, 656.704, 656.726(4), 656.745

Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0981, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 3-1991, f. 4-18-91, cert. ef. 6-1-91; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0400

Penalty and Attorney Fee for Untimely Payment of Disputed Claims Settlement

(1) Right to request penalties and attorney fees. If the insurer fails to pay amounts due on a disputed claims settlement within five business days of receipt of notice from the worker that the payment is late, the worker or worker's attorney may request penalties and attorney fees.

(2) Requirements for requests. Requests for penalties and attorney fees under this rule must be in writing, state what payments were delayed or remain unpaid, and be mailed or delivered to the division within 180 days of the date of notice to the insurer. In order to be awarded an attorney fee the attorney must submit a signed, current retainer agreement.

(3) Required response from the insurer. When notified by the director that a penalty or attorney fees have been requested under this rule, the insurer must respond in writing to the division.

(a) The response must include any information or documentation requested by the director.

(b) The response must be mailed or delivered to the division within 14 days of the date of the director's inquiry letter; and

(c) Copies of the response, including any attachments, must be sent simultaneously to the worker and the worker's attorney, if any.

(4) Failure to respond. If the insurer fails to meet the requirements of section (3) of this rule, the director may assess additional civil penalties under OAR 436-060-0200.

(5) Penalty and fee amounts. The penalty and fee will be based on the amounts allocated to the worker and the attorney in the settlement agreement as prescribed in ORS 656.262(12)(b). Penalties will be issued in accordance with the matrix set forth in Appendix "C."

(6) Timely payment of penalties. Penalties and attorney fees ordered under this rule must be paid to the worker and attorney no later than the 30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty and attorney fee will be due within 14 days of the date the order upholding the penalty becomes final. Failure to pay penalties and attorney fees in a timely manner may subject the insurer to civil penalties under OAR 436-060-0200.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.262

Hist.: WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0500

Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) General. When an insurer elects to pay supplemental disability due a worker with multiple jobs at the time of injury, the director will reimburse the supplemental amount quarterly, after receipt and approval of documentation of compensation paid by the insurer or service company. The director will reimburse the insurer, in care of the service company, if applicable.

(2) Requests for reimbursement. Requests for reimbursement must be submitted on Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," and must include at least:

(a) Identification and address of the insurer responsible for processing the claim;

(b) The worker's name, WCD file number, date of injury, Social Security number, and the insurer claim number;

(c) Whether the claim is disabling or nondisabling;

(d) The primary and secondary employers' legal names;

(e) The primary and secondary employers' policy numbers;

(f) The weekly wage of all jobs at the time of the injury separated by employer;

(g) The start and end dates for the periods of supplemental disability due and payable to the worker;

(h) The amount of supplemental disability paid for the periods in subsection (g);

(i) The quarter and year in which the payment was made;

(j) A signed payment certification statement verifying the payments; and

(k) Any other information the director requires.

(3) Administrative fee. In addition to the supplemental disability reimbursement, the director will pay the insurer an administrative fee based on the annual claim processing administrative cost factor, as published in Bulletin 316.

(4) Repayment of invalid or incorrect payments. The director may require the insurer to repay reimbursements made for invalid or incorrect payments.

(a) The director may periodically audit the insurer's files to validate the amount reimbursed.

(b) Invalid amounts include, but are not limited to:

(A) Payments exceeding statutory amounts due the insurer, excluding reasonable overpayments, as determined by the director;

(B) Compensation paid as a result of untimely or inaccurate claims processing;

(C) Payments of compensation that were not documented as required by OAR 436-050; or

(D) Amounts in a third-party recovery that result in overpayment.

(5) Benefits due workers of a noncomplying employer. Supplemental disability benefits due subject workers of a noncomplying employer as defined in ORS 656.052 are not eligible for separate reimbursement under this rule, but remain a cost recoverable from the employer as provided by ORS 656.054(2).

(6) Claim disposition agreements and stipulated claims settlements. Claim dispositions agreements or stipulated claims settlements, under ORS 656.236 or 656.289, that include amounts for supplemental disability benefits due to multiple jobs, are not eligible to receive reimbursement from the Workers' Benefit Fund unless they receive written confirmation from the director before the disposition or settlement is approved by the Worker's Compensation Board..

(a) To receive written confirmation of a proposed disposition or settlement, the insurer must submit a request to the division. The request for written confirmation must include:

(A) A copy of the proposed disposition or settlement that specifies the exact amount of the proposed contribution to be made from the Workers' Benefit Fund;

(B) A statement from the insurer indicating how the amount of the contribution was calculated; and

(C) Any other information required by the director.

(b) The director will not confirm the disposition for reimbursement if the proposed contribution exceeds a reasonable projection of that claim's future liability to the Workers' Benefit Fund.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.210
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 7-2015, f. 10-12-15, cert. ef. 1-1-16; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

436-060-0510
Reimbursement of Permanent Total Disability Benefits from the Workers' Benefit Fund

(1) General. The insurer may request reimbursement of permanent total disability benefits paid after the date of the notice of closure under ORS 656.206(6)(a).

(2) Requirements for requests. Requests for reimbursement must be filed within one year of the mailing date of the final order upholding the notice of closure and include:

(a) Sufficient information to identify the insurer and the injured worker;

(b) The net dollar amount of permanent total disability benefits paid. "Net dollar amount" means the total compensation paid less any recoveries, including, but not limited to, third party recoveries or amounts reimbursable from the Retroactive Program or Reopened Claims Program; and

(c) A statement certifying that payment has been made.

(3) Moneys due under Retroactive or Reopened Claims Programs. If any of the moneys are due under the Retroactive Program or Reopened Claims Program, any reimbursement request must be submitted under OAR 436-075 or 436-045.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.206, 656.605
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 6-2016, f. 11-28-16, cert. ef. 1-1-17

Department of Corrections
Chapter 291

Rule Caption: Shared Information Systems - Repeal
Adm. Order No.: DOC 11-2016
Filed with Sec. of State: 11-30-2016
Certified to be Effective: 11-30-16
Notice Publication Date: 10-1-2016
Rules Repealed: 291-079-0030, 291-079-0040
Subject: The Shared Information System statute (ORS 657.732) was repealed in 2011. These rules are no longer necessary since the statute has been repealed.
Rules Coordinator: Janet R. Worley—(503) 945-0933

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Department of Fish and Wildlife
Chapter 635

Rule Caption: Amend Rules Relating to Oregon Department of Fish and Wildlife Lands
Adm. Order No.: DFW 144-2016
Filed with Sec. of State: 11-17-2016
Certified to be Effective: 11-17-16
Notice Publication Date: 5-1-2016
Rules Amended: 635-008-0170, 635-008-0175
Subject: Amend language relating to the Wenaha Wildlife Area and the White River Wildlife Area
Rules Coordinator: Michelle Tate—(503) 947-6044

635-008-0170
Wenaha Wildlife Area (Wallowa County)

The Wenaha Wildlife Area is open to wildlife-oriented public use compatible with goals and objectives contained in the 2007 Wenaha Wildlife Area Management Plan unless otherwise excluded or restricted by the following rules:

(1) The area is open to the public from April 1 through December 31, except by access permit issued by ODFW. Exceptions: Year-round public access is permitted at designated camping areas, (headquarters and Griz Flat), on department land along the Wenaha River, and between the Grande Ronde river road and the Grande Ronde River from the Redmond grade bridge below Troy to the mouth of Wildcat Cr.

(2) Motorized vehicle travel is only allowed on open roads or parking areas and up to 300 feet off open roads for the purpose of moving to and from campsites.

(3) Camping is prohibited except on areas designated for that use, or by access permit issued by ODFW, and may not exceed a total of 14 days during a 30-day period.

(4) Campfires or open burning is prohibited except at campsites. Open fires are prohibited during designated fire closures.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Hist.: GC 64, f. 4-3-57; GC 232, f. 8-13-70, ef. 9-11-70; GC 252, f. 5-11-72, ef. 6-1-72, Renumbered from 630-010-0500, Renumbered from 635-015-0005; FWC 63-1980, f. & ef. 11-4-80; FWC 2-1981(Temp), f. & ef. 1-20-81; FWC 30-1982, f. & ef. 5-18-82, Renumbered from 635-008-0005(20); FWC 53-1994, f. & cert. ef. 8-25-94; DFW 27-2007 f. & cert. ef. 4-19-07; DFW 118-2007, f. 10-31-07, c ert. ef. 1-1-08; DFW 117-2014, f. & cert. ef. 8-7-14; DFW 144-2016, f. & cert. ef. 11-17-16

635-008-0175
White River Wildlife Area (Wasco County)

The White River Wildlife Area is open to wildlife-oriented public use compatible with the goals and objectives contained in the 2007 White River Wildlife Area Management Plan unless otherwise excluded or restricted by the following rules:

(1) The Wildlife Area lands north of Forest Road 27 are closed to the public from December 1 through March 31, except by access permit issued by ODFW.

(2) Motorized vehicle travel is only allowed on open roads, designated campsite or parking areas. No cross country travel or off road motor vehicle use is allowed, except by access permit issued by ODFW or for administrative use.

(3) ATV/OHV and snowmobile uses are prohibited on all area lands except by access permit issued by ODFW or for administrative use.

(4) Camping is prohibited except in designated campsites or by access permit issued by ODFW, and may not exceed 14 days in any 30 day period.

(5) Campfires and open burning are prohibited except at designated campsites. All fires are prohibited during designated fire closures.

(6) Dogs are prohibited from running at large except during authorized game bird hunting seasons or by access permit issued by ODFW.

(7) ODFW Wildlife Area Parking Permit required.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Hist.: GC 64, f. 4-3-57; GC 232, f. 8-13-70, ef. 9-11-70; GC 252, f. 5-11-72, ef. 6-1-72, Renumbered from 630-010-0500, Renumbered from 635-015-0005; FWC 63-1980, f. & ef. 11-4-80; FWC 2-1981(Temp), f. & ef. 1-20-81; FWC 30-1982, f. & ef. 5-18-82, Renumbered from 635-008-0005(21); FWC 53-1994, f. & cert. ef. 8-25-94; DFW 118-2007, f. 10-31-07, cert. ef. 1-1-08; DFW 147-2012, f. 12-18-12, cert. ef. 1-1-13; DFW 117-2014, f. & cert. ef. 8-7-14; DFW 151-2014, f. & cert. ef. 10-17-14; DFW 144-2016, f. & cert. ef. 11-17-16

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Rule Caption: Commercial Bay Dungeness Crab Fishery Closes Due To Shellfish Health Closure.
Adm. Order No.: DFW 145-2016(Temp)
Filed with Sec. of State: 11-21-2016
Certified to be Effective: 11-21-16 thru 12-31-16
Notice Publication Date:
Rules Amended: 635-005-0505
Subject: This amended rule closes the commercial bay Dungeness crab fishery due to issuance of a shellfish health closure by the Oregon Department of Agriculture. Existing permanent rule language does not adequately address closure of commercial Dungeness crab fisheries due to unsafe levels of biotoxins. Rule modifications are needed to close the fishery and to re-open the fishery when the shellfish health closure has been lifted.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-005-0505
Closed Season in Bays and Estuaries

(1) For the purposes of the Bay and Estuary Dungeness Crab Fishery, the Columbia River is considered the Pacific Ocean and is closed to all commercial harvest of Dungeness crab without a valid Ocean Dungeness Crab Permit pursuant to OAR 635-005-0405 and during the times specified in OAR 635-005-0465.

(2) It is unlawful to take, land or possess Dungeness crab for commercial purposes from any bay or estuary other than the Columbia River so taken:

(a) From January 1 through Labor Day;

(b) During December, if the adjacent ocean area is closed as provided in 635-005-0465;

(c) From midnight Friday through midnight Sunday of any week;

(d) On all legal state and federal holidays; and

(e) From a health closure area closed for biotoxins. A"health closure area" means an area closed to the public due to health risks of consuming shellfish from the area; and "biotoxins" means naturally occurring shellfish toxins monitored by the Oregon Department of Agriculture.

Stat. Auth.: ORS 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109, 506.129 & 506.306
Hist.: FWC 70-1993, f. 11-9-93, cert. ef. 11-11-93; Renumbered from 635-005-0049, DFW 76-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 156-2015(Temp), f. & cert. ef. 11-13-15 thru 12-31-15; Administrative correction, 1-22-16; DFW 145-2016(Temp), f. & cert. ef. 11-21-16 thru 12-31-16

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Rule Caption: Commercial Dungeness Crab Fishery Opener Delayed Due to Unsafe Levels of Domoic Acid.
Adm. Order No.: DFW 146-2016(Temp)
Filed with Sec. of State: 11-23-2016
Certified to be Effective: 11-23-16 thru 5-21-17
Notice Publication Date:
Rules Amended: 635-005-0465
Subject: This amended rule delays the opening of the 2016-2017 commercial Dungeness crab season in the Pacific ocean and Columbia River due to elevated levels of the biotoxin domoic acid detected in samples of crab viscera during preseason testing. The season opening set in permanent rule is December 1. A new opening date for these fisheries has not been set, will depend on the results of further testing, and may differ regionally. Commercial Dungeness crab fisheries in bays and estuaries have already been closed in accordance with the provisions of Temporary OAR 635-005-0505(2)(e) which became effective November 21, 2016.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-005-0465
Closed Season in Pacific Ocean and Columbia River

(1) It is unlawful to take, land or possess Dungeness crab for commercial purposes from the Pacific Ocean or Columbia River.

(2) The season opening for the commercial Ocean Dungeness crab fishery may be delayed in one or more fishing zones based on the results of crab quality or biotoxin testing. The Pre-season Testing Protocol for the Tri-State Coastal Dungeness crab Commercial Fishery (hereafter, "Tri-State Protocol") specifies the process for establishing fishing zones (section VI) and coordinating the opening of the fishery in Washington, Oregon, and California north of PointArena (sections IV and V). Therefore, the following sections of the Tri-State Protocol (Revised July 2014) are hereby incorporated into Oregon Administrative Rule by reference:

(a) Section IV — Season Opening Criteria.

(b) Section V — Test Fishing and Process for Setting the Season Opening Date.

(c) Section VI — Procedure for Establishing Fishing Zones. In the event that crab quality tests do not meet the criteria for opening the season on December 1, the Director shall adopt temporary rules delaying the season in accordance with the Tri-State Protocol. In the event that areas within the Tri-State area are delayed due to elevated levels of biotoxins, a vessel used for fishing crab in an open zone may not be used for fishing crab in a delayed zone until 30 days after the delayed zone has opened. The fisher must declare on the pre-season hold inspection certificate the zone in which the vessel will start fishing.

(3) It is unlawful to land, receive or buy, Dungeness crab in the first thirty days of the ocean Dungeness crab fishery from a vessel that has not been certified by officials of the State of Oregon, Washington, or California to have been free of Dungeness crab before fishing in the ocean Dungeness crab fishery. In the event the area between Gray's Harbor, Washington and Point Arena, California is divided into zones with different season opening dates, the ocean Dungeness crab fishery refers to the fishery in that zone for the purposes of this rule.

(4) Upon a determination by the Department that catch in Oregon's ocean Dungeness crab fishery after May 31 is greater than ten percent of the catch in the previous December 1 through May 31 period, the Director shall adopt a temporary rule closing the commercial season until the following December 1.

Stat. Auth.: ORS 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109, 506.129 & 506.306
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 285(74-20), f. 11-27-74, ef. 12-25-74; FC 293(75-6), f. 6-23-75, ef. 7-11-75; FWC 30, f. & ef. 11-28-75; FWC 132, f. & ef. 8-4-77; FWC 30-1985, f. 6-27-1985, ef. 7-1-85, Renumbered from 625-010-0155, Renumbered from 635-036-0125; FWC 56-1982, f. & ef. 8-27-82; FWC 13-1983, f. & ef. 3-24-83; FWC 39-1983(Temp), f. & ef. 8-31-83; FWC 11-1984, f. 3-30-84, ef. 9-16-84, except section (1) per FWC 45-1984, f. & ef. 8-30-84; FWC 30-1985, f. 6-27-85, ef. 7-1-85; FWC 78-1986(Temp), f. & ef. 12-1-86; FWC 36-1987, f. & ef. 7-1-87; FWC 97-1987(Temp), f. & ef. 11-17-87; FWC 102-1988, f. 11-29-88, cert. ef. 12-29-88; FWC 119-1989(Temp), f. 11-29-89, cert. ef. 12-1-89; FWC 135-1991(Temp), f. 12-10-91, cert. ef. 12-11-91; FWC 136-1991(Temp), f. & cert. ef. 12-19-91; FWC 112-1992, f. 10-26-92, cert. ef. 11-1-92; FWC 70-1993, f. 11-9-93, cert. ef. 11-11-93; FWC 88-1994(Temp), f. 11-30-94, cert. ef. 12-1-94; FWC 89-1994(Temp), f. & cert. ef. 12-1-94; FWC 89-1995(Temp), f. 11-28-95, cert. ef. 12-1-95; FWC 1-1996(Temp), f. 1-11-96, cert. ef. 1-13-96; DFW 51-1998(Temp), f. 6-29-98, cert. ef. 7-1-98 thru 9-15-98; DFW 54-1998(Temp), f. & cert. ef. 7-24-98 thru 9-15-98; DFW 40-1999, f. & cert. ef. 5-26-99; DFW 70-2000, f. & cert. ef. 10-23-00; DFW 77-2000(Temp), f. 11-27-00, cert. ef. 12-1-00 thru 12-14-00; DFW 39-2002, f. & cert. ef. 4-26-02; DFW 128-2002(Temp), f. & cert. ef. 11-15-02 thru 1-31-03; DFW 129-2002(Temp), f. & cert. ef. 11-20-02 thru 1-31-03; DFW 132-2002(Temp), f. & cert. ef. 11-25-02 thru 1-31-03 (Suspended by DFW 133-2002(Temp)); DFW 133-2002(Temp), f. & cert. ef. 12-6-02 thru 1-31-03; DFW 117-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 2-29-04; Administrative correction 10-26-04; DFW 113-2004(Temp), f. 11-23-04, cert. ef. 12-1-04 thru 3-1-05; DFW 116-2004(Temp), f. & cert. ef. 12-8-04 thru 3-1-05; DFW 126-2004(Temp), f. & cert. ef. 12-21-04 thru 3-1-05; DFW 132-2004(Temp), f. & cert ef. 12-30-04 thru 3-1-05; Administrative correction, 3-18-05; DFW 129-2005(Temp), f. & cert. ef. 11-29-05 thru 12-31-05; DFW 140-2005(Temp), f. 12-12-05, cert. ef. 12-30-05 thru 5-31-06; Administrative correction 7-20-06; DFW 142-2008, f. & cert. ef. 11-21-08; DFW 161-2010(Temp), f. 12-9-10, cert. ef. 12-10-10 thru 2-16-11; Administrative correction, 3-29-11; 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; Administrative correction 4-24-12; DFW 37-2012, f. 4-24-12, cert. ef. 5-1-12; Renumbered from 635-005-0045, DFW 76-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 145-2012(Temp), f. 11-14-12, cert. ef. 12-1-12 thru 12-31-12; DFW 146-2012(Temp), f. 12-11-12, cert. ef. 12-12-12 thru 6-9-13; Administrative correction, 6-27-13; DFW 118-2013, f. 10-11-13, cert. ef. 10-15-13: DFW 129-2013(Temp), f. 11-25-13, cert. ef. 12-1-13 thru 12-31-13; Administrative correction, 2-5-14; DFW 113-2014, f. 8-5-14, cert. ef. 8-15-14; DFW 157-2014(Temp), f. 11-24-14, cert. ef. 11-25-14 thru 5-23-15; Administrative correction, 6-23-15; DFW 150-2015, f. & cert. ef. 10-29-15; DFW 157-2015(Temp), f. & cert. ef. 11-20-15 thru 1-31-16; DFW 166-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; DFW 146-2016(Temp), f. & cert. ef. 11-23-16 thru 5-21-17

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Rule Caption: Rules for Recreational and Commercial Fisheries in the Columbia River.
Adm. Order No.: DFW 147-2016
Filed with Sec. of State: 12-7-2016
Certified to be Effective: 12-15-16

Notice Publication Date: 11-1-2016
Rules Amended: 635-500-6715, 635-500-6720, 635-500-6725, 635-500-6730, 635-500-6735, 635-500-6740, 635-500-6745, 635-500-6750
Subject: These amended rules modify recreational and commercial fisheries in the Columbia River and tributaries. Housekeeping and technical corrections to the regulations were made to ensure rule consistency.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-500-6715
Spring Chinook

(1) Transition Period (2013-2017).

(a) In 2013, assign 65%, then 70% of the ESA-impact for upriver spring Chinook stocks to mainstem recreational fisheries.

(b) In 2013, assign 35%, then 30% to off-channel and mainstem commercial fisheries.

(2) Long Term (2018 and Beyond).

(a) Assign 80% of the ESA-impact to mainstem recreational fisheries.

(b) Assign 20% to commercial fisheries.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 147-2016, f. 12-7-16, cert. ef. 12-15-16

635-500-6720
Summer Chinook

(1) Transition Period (2013-2017).

(a) In 2013-14, assign 60%, then 70% of the harvestable surplus available for use downstream from Priest Rapids Dam to mainstem recreational fisheries.

(b) In 2013-14, assign 40%, then 30% to off-channel and mainstem commercial fisheries.

(2) Long Term (2018 and Beyond).

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 147-2016, f. 12-7-16, cert. ef. 12-15-16

635-500-6725
Sockeye

(1) Transition Period (2013-2017).

(a) Assign 70% of the ESA-impact for Snake River sockeye to mainstem recreational fisheries.

(b) Assign 30% to mainstem commercial fisheries for incidental harvest of sockeye in Chinook-directed fisheries.

(2) Long Term (2018 and Beyond).

(a) Assign approximately 80% of the ESA-impact for Snake River sockeye to mainstem recreational fisheries.

(b) Assign the remaining balance to commercial fisheries for incidental harvest of sockeye in Chinook-directed fisheries.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 147-2016, f. 12-7-16, cert. ef. 12-15-16

635-500-6730
Tule Fall Chinook

(1) Transition Period (2013-2017).

(a) Assign no more than 70% of the ESA-impact for lower Columbia River Tule fall Chinook to mainstem recreational fisheries.

(b) Assign not less than 30% to off-channel commercial fisheries, mainstem commercial fisheries that target Upriver Bright and Lower River Hatchery Fall Chinook.

(2) Long Term (2018 and Beyond).

(a) Assign no more than 80% of the ESA-impact for lower Columbia River Tule Fall Chinook to mainstem recreational fisheries.

(b) Assign not less than 20% to off-channel commercial fisheries and mainstem commercial fisheries that target Upriver Bright and Lower River Hatchery Fall Chinook and hatchery coho.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 147-2016, f. 12-7-16, cert. ef. 12-15-16

635-500-6735
Upriver Bright Fall Chinook

(1) Transition Period (2013-2017).

(a) Assign no more than 70% of the ESA-impact for Snake River Wild Fall Chinook to mainstem recreational fisheries.

(b) Assign not less than 30% to off-channel and mainstem commercial fisheries. Provide additional mainstem commercial harvest when recreational fishery objectives (OAR 635-500-6760) are expected to be met.

(2) Long Term (2018 and Beyond).

(a) Assign no more than 80% of the ESA-impact for Snake River Wild Fall Chinook to mainstem recreational fisheries.

(b) Assign not less than 20% to off-channel and mainstem commercial fisheries. Provide additional mainstem commercial harvest when recreational fishery objectives (OAR 635-500-6760) are expected to be met.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 147-2016, f. 12-7-16, cert. ef. 12-15-16

635-500-6740
Coho

(1) Transition Period (2013-2017).

(a) Assign commercial fisheries a sufficient share of the ESA-impact for Lower Columbia Natural coho to implement off-channel coho and fall Chinook fisheries and mainstem fall Chinook fisheries.

(b) Assign the remaining balance to in-river mainstem recreational fisheries. If these fisheries are expected to be unable to use all of the ESA-impact for Lower Columbia Natural coho, assign the remainder to mainstem commercial coho fisheries.

(2) Long Term (2018 and Beyond).

(a) Assign commercial fisheries a sufficient share of the ESA-impact for Lower Columbia Natural coho to implement off-channel coho and fall Chinook fisheries and mainstem fall Chinook and hatchery coho fisheries.

(b) Assign the balance to in-river mainstem recreational fisheries. If these fisheries are unable to use all of the ESA-impact for Lower Columbia Natural coho, assign the remainder to mainstem commercial coho fisheries.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 147-2016, f. 12-7-16, cert. ef. 12-15-16

635-500-6745
Chum

(1) Transition Period (2013-2017).

(a) Assign commercial fisheries a sufficient share of the ESA-impact for chum to implement off-channel and mainstem fisheries targeting other salmon species.

(b) Prohibit the retention of chum salmon in recreational and commercial fisheries.

(2) Long Term (2018 and Beyond).

(a) Assign commercial fisheries a sufficient share of the ESA-impact for chum to implement off-channel and mainstem fisheries targeting other salmon species.

(b) Prohibit the retention of chum salmon in recreational and commercial fisheries

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 147-2016, f. 12-7-16, cert. ef. 12-15-16

635-500-6750
White Sturgeon

(1) Transition Period (2013-2017).

(a) In years when retention is allowed, allocate 90% of the harvestable surplus downstream from Bonneville Dam for use in non-tribal fisheries and hold 10% in reserve as an additional conservation buffer above the maximum harvest rate allowed in Oregon's white sturgeon conservation plan.

(b) Assign 80% of the white sturgeon available for harvest to the recreational fishery.

(c) Assign 20% to off-channel and mainstem commercial fisheries.

(2) Long Term (2018 and Beyond).

(a) In years when retention is allowed, allocate 90% of the harvestable surplus downstream from Bonneville Dam for use in non-tribal fisheries and hold 10% in reserve as an additional conservation buffer above the maximum harvest rate allowed in Oregon's white sturgeon conservation plan.

(b) Assign 80% of the white sturgeon available for harvest to the recreational fishery.

(c) Assign the balance (20%) to off-channel and mainstem commercial fisheries.

Stat. Auth.: ORS 496.138, 496.146 & 506.119

Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 147-2016, f. 12-7-16, cert. ef. 12-15-16

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Rule Caption: Amendments to Rules for Commercial and Recreational Groundfish Fisheries.
Adm. Order No.: DFW 148-2016
Filed with Sec. of State: 12-7-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 11-1-2016
Rules Amended: 635-004-0330, 635-004-0350, 635-004-0355, 635-039-0090
Subject: The amended rules establish annual groundfish management measures and harvest limits for 2017 commercial and sport groundfish fisheries. Housekeeping and technical corrections to the regulations were made to ensure rule interpretation consistency.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-004-0330
Transferability of Permits

(1) Any transfer of a permit away from a vessel without the written consent of each person holding a security interest in such vessel is void.

(2) Black Rockfish/Blue Rockfish/Nearshore Fishery Permit holders may transfer a permit pursuant to ORS 508.957.

(3) To be eligible for transfer the vessel operating under the permit must have made, in the previous calendar year, a minimum of five landings that contained at least 15 pounds of any combination of black rockfish, blue rockfish or nearshore fish in each landing.

Stat. Auth.: ORS 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109, 506.129 & 508.957
Hist.: DFW 75-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 148-2016, f. 12-7-16, cert. ef. 1-1-17

635-004-0350
Harvest Guidelines and Landing Caps

(1) Upon attainment of a harvest guideline in the Black Rockfish/Blue Rockfish/Nearshore Fishery, the Department shall initiate consultation to determine if additional regulatory actions are necessary to achieve management objectives.

(2) The following commercial harvest guidelines include the combined landings and other fishery related mortality by all Oregon commercial fisheries in a single calendar year:

(a) Black rockfish: 126.3 metric tons;

(b) Cabezon: 30.2 metric tons;

(c) Blue rockfish, deacon rockfish and other nearshore rockfish combined: 13.0 metric tons; and

(d) Greenling: 169.9 metric tons.

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 151-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 136-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 4-2015, f. 1-13-15, cert. ef. 1-15-15; DFW 3-2016, f. & cert. ef. 1-19-16; DFW 148-2016, f. 12-7-16, cert. ef. 1-1-17

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) 1500 pounds in period 2;

(C) 1800 pounds in period 3;

(D) 1800 pounds in period 4;

(E) 1500 pounds in period 5;

(F) 1200 pounds in period 6; and

(b) 300 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) 450 pounds of other nearshore rockfish combined;

(b) 2000 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; DFW 114-2016(Temp), f. 9-12-16, cert. ef. 9-15-16 thru 12-31-16; DFW 143-2016(Temp), f. & cert. ef. 11-10-16 thru 12-31-16; DFW 148-2016, f. 12-7-16, cert. ef. 1-1-17

635-039-0090
Inclusions and Modifications

(1) The **2017 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 2017 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, 400.1 metric tons.

(B) Cabezon, 16.8 metric tons.

(C) Blue rockfish, deacon rockfish, and other nearshore rockfish combined, 33.1 metric tons.

(D) Greenling, 56.3 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 2017 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 2017 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 six may be black rockfish, no more than four may be blue rockfish, deacon rockfish, China rockfish, copper rockfish, or quillback rockfish in aggregate, and no more than one may be a cabezon. Retention of the following species is prohibited:

(A) Yelloweye rockfish; and

(B) 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) May be taken by angling, hand, bow and arrow, spear, gaff hook, snag hook and herring jigs.

(D) Mutilating the fish so the size or species cannot be determined prior to landing or transporting mutilated fish across state waters is prohibited.

(E) All vessels engaged in sport fishing activities shall have a functional descending device on board when fishing for groundfish in the Pacific Ocean or when in possession of groundfish. A descending device shall be used when releasing any rockfish outside of the 30-fathom curve (defined by latitude and longitude) as shown in Title 50 Code of Federal Regulations Part 660 Section 71. Upon request, a descending device shall be presented for inspection by any person authorized to enforce the recreational fishing laws of Oregon or a representative of the Department. In this subsection, "descending device" means a device capable of returning a rockfish back to a depth of at least 100 feet to assist the fish in recompression and to improve the fish's chance of survival.

(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 September 30, outside of the 30-fathom curve (defined by latitude and longitude) as shown in 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; DFW 105-2016, f. & cert. ef. 8-10-16; DFW 117-2016(Temp), f. 9-14-16, cert. ef. 10-1-16 thru 12-31-16; DFW 148-2016, f. 12-7-16, cert. ef. 1-1-17

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Rule Caption: Forage Fish Management Plan Implementation.
Adm. Order No.: DFW 149-2016
Filed with Sec. of State: 12-7-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 8-1-2016
Rules Adopted: 635-004-0223, 635-005-0263
Rules Amended: 635-004-0215, 635-005-0240, 635-005-0915, 635-006-0210
Subject: These adopted and amended rules bring Oregon 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 the new Oregon Forage Fish Management Plan, modifications to the regulations 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. Modifications to rules for fish ticket requirements 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—(503) 947-6044

635-004-0215
Definitions

As used in Division 004 regulations:

(1) "Animals living intertidally on the bottom" means any benthic animal with a natural range that includes intertidal areas, regardless of where harvest occurs, and includes but is not limited to, starfish, sea urchins, sea cucumbers, snails, bivalves, worms, coelenterates, and crabs except Dungeness crab.

(2) "Board" means the Commercial Fishery Permit Board.

(3) "Buy" includes offer to buy, barter, exchange or trade.

(4) "Coastal Pelagic Species" means all species of ocean food fish and shellfish defined as Coastal Pelagic Species in the Fishery Management Plan for U.S. West Coast Fisheries for Coastal Pelagic Species and in the Federal Coastal Pelagic Species Regulations, Title 50, Part 660, and include:

(a) Jack mackerel (*Trachurus symmetricus*);

(b) Jack smelt (*Atherinopsis californiensis*);

(c) Krill (all species in order *Euphausiacea*);

(d) Market squid (*Loligo opalescens*);

(e) Northern anchovy (*Engraulis mordax*);

(f) Pacific herring (*Clupea harengus pallasi*);

(g) Pacific mackerel (*Scomber japonicus*); and

(h) Pacific sardine (*Sardinops sagax*).

(5) "Commercial harvest cap" means the total fishery-related mortality for a given species, or species group, that may occur in a single calendar year in Oregon commercial fisheries.

(6) "Commercial landing cap" means the total landed catch of a given species, or species group, that may be taken in a single calendar year in Oregon commercial fisheries.

(7) "Commercial purposes" means taking food fish with any gear unlawful for angling, or taking or possessing food fish in excess of the limits permitted for personal use, or taking, fishing for, handling, processing, or otherwise disposing of or dealing in food fish with the intent of disposing of such food fish or parts thereof for profit, or by sale, barter or trade, in commercial channels, as specified in ORS 506.006.

(8) "Commission" means the State Fish and Wildlife Commission created by ORS 496.090.

(9) "Department" means the State Department of Fish and Wildlife.

(10) "Director" means the Director of the Oregon Department of Fish and Wildlife appointed pursuant to ORS 496.112.

(11) "Dive gear" means gear used while a fisher is submerged underwater in order to take food fish, and includes but is not limited to one or more of the following pieces of equipment: SCUBA or other surface supplied air source (hookah gear), dive mask, snorkel, air cylinders, weight belt, wetsuit and fins.

(12) "Exclusive Economic Zone" means the zone between 3-200 nautical miles offshore of the United States.

(13) "Fishing gear" means, as specified in ORS 506.006, any appliance or device intended for or capable of being used to take food fish for commercial purposes, and includes:

(a) "Fixed gear" means longline, trap or pot, set net, and stationary hook-and-line gears;

(b) "Gillnet" has the meaning as set forth in OAR 635-042-0010;

(c) "Hook-and-line" means one or more hooks attached to one or more lines;

(d) "Lampara net" means a surrounding or seine net with the sections of netting made and joined to create bagging, and is hauled with purse rings;

(e) "Longline" means a stationary buoyed, and anchored groundline with hooks attached;

(f) "Mesh size" means the opening between opposing knots. Minimum mesh size means the smallest distance allowed between the inside of one knot to the inside of the opposing knot regardless of twine size;

(g) "Pot or trap" means a portable, enclosed device with one or more gates or entrances and one or more lines attached to surface floats;

(h) "Purse seine" means an encircling net that may be closed by a purse line threaded through the bottom of the net. Purse seine gear includes ring net, drum purse seine, and lampara nets;

(i) "Seine" means any non-fixed net other than a trawl net or gillnet and includes all types of purse seines;

(j) "Setline" means a bottom longline used in rivers and estuaries for targeting white sturgeon;

(k) "Set net" means a stationary, buoyed and anchored gillnet or trammel net which takes fish commonly by gilling and is not free to move or drift with the current or tide;

(l) "Spear" means a sharp, pointed, or barbed instrument on a shaft;

(m) "Trammel net" means a gillnet made with two or more walls joined to a common float line;

(n) "Trawl gear" means a cone or funnel-shaped net which is towed or drawn through the water by one or two vessels, and includes but is not limited to beam trawl, bobbin or roller trawl, bottom trawl, pelagic trawl and Danish and Scottish seine gear;

(o) "Troll" means fishing gear that consists of 1 or more lines that drag hooks with bait or lures behind a moving fishing vessel, and which lines are affixed to the vessel and are not disengaged from the vessel at any time during the fishing operation; and

(p) "Vertical hook and line" means a line attached to the vessel or to a surface buoy vertically suspended to the bottom by a weight or anchor, with hooks attached between its surface and bottom end.

(14) "Fishing trip" means a period of time between landings when fishing is conducted.

(15) "Food Fish" means any animal over which the State Fish and Wildlife Commission has jurisdiction, pursuant to ORS 506.036.

(16) "Groundfish" means all species of ocean food fish defined as groundfish in the Pacific Coast Groundfish Fishery Management Plan and in the Federal Groundfish Regulations, Title 50, Part 660 and includes:

(a) All species of rockfish, thornyheads, and scorpionfish that occur off Washington, Oregon, or California (genera Sebastes, Scorpaena, Scorpaenodes, and Sebastolobus);

(b) All species of grenadiers in the family Macrouridae that occur off Washington, Oregon, or California, including but not limited to Giant grenadier, (Albatrossia pectoralis) and Pacific grenadier (Coryphaenoides acrolepis);

(c) All species of skates in the family Arhynchobatidae that occur off Washington, Oregon, or California, including but not limted to Aleutian skate (Bathyraja aleutica), Bering/sandpaper skate (B. interrupta), big skate (Raja binoculata), California skate (R. inornata), longnose skate (R. rhina), and roughtail/black skate (B. trachura);

(d) Arrowtooth flounder (Atheresthes stomias);

(e) Butter sole (Isopsetta isolepis);

(f) Cabezon (Scorpaenichthys marmoratus);

(g) Curlfin sole (Pleuronichthys decurrens);

(h) Dover sole (Microstomus pacificus);

(i) English sole (Parophrys vetulus);

(j) Finescale codling (Antimora microlepis);

(k) Flathead sole (Hippoglossoides elassodon);

(l) Kelp greenling (Hexagrammos decagrammus);

(m) Leopard shark (Triakis semifasciata);

(n) Lingcod (Ophiodon elongatus);

(o) Pacific cod (Gadus macrocephalus);

(p) Pacific sanddab (Citharichthys sordidus);

(q) Pacific whiting (Merluccius productus);

(r) Petrale sole (Eopsetta jordani);

(s) Ratfish (Hydrolagus colliei);

(t) Rex sole (Glyptocephalus zachirus);

(u) Rock sole (Lepidopsetta bilineata);

(v) Sablefish (Anoplopoma fimbria);

(w) Sand sole (Psettichthys melanostictus);

(x) Soupfin shark (Galeorhinus zyopterus);

(y) Spiny dogfish (Squalus acanthias); and

(z) Starry flounder (Platichthys stellatus).

(17) "Harvest guideline" means a specified numerical harvest objective that is not a quota. Attainment of a harvest guideline does not automatically close a fishery.

(18) "Highly Migratory Species" means all species of ocean food fish defined as highly migratory species in the Fishery Management Plan for U.S. West Coast Fisheries for Highly Migratory Species and in the Federal Highly Migratory Species Regulations, Title 50, Part 660, and includes:

(a) Bigeye thresher shark (Alopias superciliosus);

(b) Bigeye tuna (Thunnus obesus);

(c) Blue shark (Prionace glauca);

(d) Common thresher shark (Alopias vulpinus);

(e) Common Mola (Mola mola);

(f) Dorado (Coryphaena hippurus);

(g) Escolar (Lepidocybium flavobrunneum);

(h) Lancetfishes (Alepisauridae species);

(i) Louvar (Luvarus imperialis);

(j) North Pacific albacore tuna (Thunnus alalunga);

(k) Northern bluefin tuna (Thunnus thynnus);

(l) Pacific swordfish (Xiphias gladius);

(m) Pelagic sting ray (Dasyetis violacea);

(n) Pelagic thresher shark (Alopias pelagicus);

(o) Shortfin mako shark (Isurus oxyrinchus);

(p) Skipjack tuna (Katsuwonus pelamis);

(q) Striped marlin (Tetrapturus audax);

(r) Wahoo (Acathocybium solandri); and

(s) Yellowfin tuna (Thunnus albacares).

(19) "Inland waters" means all waters of the state except the Pacific Ocean.(20) "Intertidal" means the area in Oregon coastal bays, estuaries, and beaches between mean extreme low water and mean extreme high water boundaries.

(21) "Land, landed, or landing" means either of the following:

(a) For fisheries where food fish were taken by use of a vessel, "land, landed or landing" means to begin transfer of food fish from a vessel. Once transfer begins, all food fish aboard the vessel are counted as part of that landing, except:

(A) Anchovies being held live on a vessel for the purpose of using for bait in that vessel's commercial fishing operation; and

(B) For vessels participating in the federal trawl rationalization program, the portion of catch that is intended to be delivered to Washington or California is not considered part of that landing.

(b) For fisheries where food fish were taken without use of any vessel, "land, landed or landing" means to begin transfer of food fish from a harvester to a wholesale fish dealer, wholesale fish bait dealer, or food fish canner, under which the following provisions apply:

(A) When the harvester and the wholesale fish dealer, wholesale fish bait dealer, or food fish canner are the same person or entity, transfer occurs when the food fish arrive at the licensed premises of the wholesale fish dealer, wholesale fish bait dealer, or food fish canner; and

(B) Once transfer begins, all food fish from the harvest area are counted as part of that landing.

(22) "Length" or "Length Overall" of a vessel means the manufacturer's specification of overall length, United States Coast Guard or Marine Board registered length documentation stating overall length or overall length as surveyed by a certified marine surveyor. In determining overall length, marine surveyors shall measure in a straight line parallel to the keel from the foremost part of the vessel to the aftermost part, excluding sheer and excluding bow sprits, boomkins, rudders aft of the transom, outboard motor brackets, or transom extensions such as a dive step or platform.

(23) "Length, total" of a fish is measured from the tip of the snout (mouth closed) to the tip of the tail (pinched together) without mutilation of the fish or the use of additional force to extend the length.

(24) "Nearshore species" includes (See ORS 506.011):

(a) Black and yellow rockfish (Sebastes chrysolmelas);

(b) Brown Irish lord (Hemilepidotus spinosus);

(c) Brown rockfish (Sebastes auriculatus);

(d) Buffalo sculpin (Enophrys bison);

(e) Cabezon (Scorpaenichthys marmoratus);

(f) Calico rockfish (Sebastes dalli);

(g) China rockfish (S. nebulosus);

(h) Copper rockfish (S. caurinus);

(i) Gopher rockfish (S. carnatus);

(j) Grass rockfish (S. rastrelliger);

(k) Kelp greenling (Hexagrammos decagrammus);

(l) Kelp rockfish (Sebastes atrovirens);

(m) Olive rockfish (S. serranoides);

(n) Painted greenling (Oxylebius pictus);

(o) Quillback rockfish (Sebastes maliger);

(p) Red Irish lord (Hemilepidotus hemilepidotus);

(q) Rock greenling (Hexagrammos lagocephalus);

(r) Tiger rockfish (Sebastes nigrocinctus);

(s) Treefish (S. serriceps);

(t) Vermillion rockfish (S. miniatus); and

(u) White spotted greenling (Hexagrammos stelleri).

(25) "Ocean food fish" means all saltwater species of food fish except salmon, halibut, and shellfish whether found in fresh or salt water.

(26) "Other nearshore rockfish" includes:

(a) Black and yellow rockfish (Sebastes chrysolmelas);

(b) Brown rockfish (S. auriculatus);

(c) Calico rockfish (S. dalli);

(d) China rockfish (S. nebulosus);

(e) Copper rockfish (S. caurinus);

(f) Gopher rockfish (S. carnatus);

(g) Grass rockfish (S. rastrelliger);

(h) Kelp rockfish (S. atrovirens);

(i) Olive rockfish (S. serranoides);

(j) Quillback rockfish (S. maliger); and

(k) Treefish (S. serriceps).

(27) "Pacific Ocean" means all water seaward of the end of the jetty or jetties of any river, bay, or tidal area, except the Columbia River boundary with the Pacific Ocean is as specified in OAR 635-003-0005, or all water seaward of the extension of the shoreline high watermark across the river, bay, or tidal area where no jetties exist.

(28) "Permit holder" means a person or entity that owns an individual permit or owns the vessel to which a vessel permit is attached. A lessee of a permit is not a permit holder.

(29) "Possession" means holding any food fish, shellfish or parts thereof in a person's custody or control.

(30) "Process or Processing" means fresh packaging requiring freezing of food fish, or any part thereof, or any type of smoking, reducing, loining, steaking, pickling or filleting.

(31) "Resident" means an actual bona fide resident of this state for at least one year, as specified in ORS 508.285.

(32) "Rockfish" includes all species in the following genera:

(a) Sebastes; and

(b) Sebastolobus.

(33) "Salmon" means all anadromous species of salmon, including but not limited to:

(a) Oncorhynchus gorbuscha, commonly known as humpback, humpies or pink salmon.

(b) Oncorhynchus keta, commonly known as chum or dog salmon.

(c) Oncorhynchus kisutch, commonly known as coho or silver salmon.

(d) Oncorhynchus nerka, commonly known as sockeye, red or blueback salmon.

(e) Oncorhynchus tshawytscha, commonly known as Chinook salmon.

(34) "Shared Ecosystem Component Species" means those ecosystem component species shared between all of the Pacific Fishery Management Council's Fishery Management Plans which occur in the Pacific Ocean off Oregon and include:

(a) Mesopelagic fishes of the families Myctophidae, Bathylagidae, Paralepididae, and Gonostomatidae;

(b) Pacific sand lance (Ammodytes hexapterus);

(c) Pacific saury (Cololabis saira);

(d) Silversides of the family Atherinopsidae;

(e) Smelts of the family Osmeridae; and

(f) Pelagic squids of the families Cranchiidae, Gonatidae, Histioteuthidae, Octopoteuthidae, Ommastrephidae except Humboldt squid (Dosidicus gigas), Onychoteuthidae, and Thysanoteuthidae.

(35) "Security interest" means an interest in a vessel or permit granted by the owner of the vessel or permit to a third party under a security agreement, pursuant to ORS chapter 79, another state's laws enacted to implement Article 9 of the Uniform Commercial Code or equivalent federal statutory provisions for federally documented vessels.

(36) "Sell" includes to offer or possess for sale, barter, exchange or trade.

(37) "Smelt" means all species in the family Osmeridae.

(38) "Take" means fish for, hunt, pursue, catch, capture or kill or attempt to fish for, hunt, pursue, catch, capture or kill.

(39) "Transport" means transport by any means, and includes offer or receive for transportation.

(40) "Trip limit" means the total amount of fish that may be taken and retained, possessed, or landed per vessel from a single fishing trip or cumulatively per unit of time. A vessel which has landed its cumulative or daily limit may continue to fish on the limit for the next legal period as long as the fish are not landed until the next period. Trip limits may be:

(a) "Bi-monthly cumulative trip limit" means the maximum amount of fish that may taken and retained, possessed or landed per vessel in specified bi-monthly periods. There is no limit on the number of landings or trips in each period, and periods apply to calendar months. The specified periods are as follows:

(A) Period 1: January through February;

(B) Period 2: March through April;

(C) Period 3: May through June;

(D) Period 4: July through August;

(E) Period 5: September through October; and

(F) Period 6: November through December.

(b) "Daily trip limit" means the maximum amount of fish that may be taken and retained, possessed or landed per vessel in 24 consecutive hours, starting at 00:01 hours local time. Only one landing of groundfish may be made in that 24-hour period;

(c) "Monthly trip limit" means the maximum amount of fish that may be taken and retained, possessed or landed per vessel during the first day through the last day of any calendar month.

(d) "Weekly trip limit" means the maximum amount of fish that may be taken and retained, possessed or landed per vessel in seven (7) consecutive days, starting at 00:01 hours local time on Sunday and ending at 24:00 hours local time on Saturday. Weekly trip limits may not be accumulated during multiple week trips. If a calendar week falls within two different months or two different cumulative limit periods, a vessel is not entitled to two separate weekly limits during that week.

(41) "Undue hardship" means death, serious illness requiring extended care by a physician, permanent disability, or other circumstances beyond the individual's control.

(42) "Unlawful to buy" means that it is unlawful to buy, knowing or having reasonable cause to believe that the fish have been illegally taken or transported within this state, or unlawfully imported or otherwise unlawfully brought into this state.

(43) "Vessel" means any floating craft, powered, towed, rowed or otherwise propelled which is used for landing or taking food fish for commer-

cial purposes, and has the same meaning as 'boat' as specified in ORS 506.006.

(44) "Vessel operator" means the person onboard a fishing vessel who is responsible for leading a fishing vessel in fishing or transit operations, and who signs the corresponding fish ticket from that fishing trip. A vessel operator may be a vessel owner or permit holder or both, individual hired to operate a vessel, or lessee of a vessel, permit or both. Although more than one person may physically operate a vessel during a fishing trip or transit, there may only be one person identified as a vessel operator (commonly referred to as a captain or skipper) on a fishing vessel during any one fishing trip or transit.

(45) "Vessel owner" means any ownership interest in a vessel, including interests arising from partnerships, corporations, limited liability corporations, or limited liability partnerships. A vessel owner does not include a leasehold interest.

(46) "Waters of this state" means all waters over which the State of Oregon has jurisdiction, or joint or other jurisdiction with any other state or government, including waters of the Pacific Ocean and all bays, inlets, lakes, rivers and streams within or forming the boundaries of this state.

(47) "Week" means the period beginning at 00:01 hours local time on Sunday and ending at 24:00 hours local time on the following Saturday.

Stat. Auth.: ORS 496.138, 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 496.162, 506.109 & 506.129
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FWC 37, f. & ef. 1-23-76, Renumbered from 625-010-0545; FWC 49-1979, f. & ef. 11-1-79, Renumbered from 635-036-0270; FWC 10-1983, f. & ef. 3-1-83; FWC 1-1985(Temp), f. & ef. 1-4-85; FWC 5-1985, f. & ef. 2-19-85; FWC 17-1987(Temp), f. & ef. 5-7-87; FWC 103-1988, f. 12-29-88, cert. ef. 1-1-89; FWC 28-1989(Temp), f. 4-25-89, cert. ef. 4-26-89; FWC 130-1990, f. 12-31-90, cert. ef. 1-1-91; FWC 67-1991, f. 6-25-91, cert. ef. 7-1-91; FWC 21-1992(Temp), f. 4-7-92, cert. ef. 5-1-92; FWC 141-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 21-1992(Temp), f. 4-7-92, cert. ef. 5-1-92; FWC 36-1992, f. 5-26-92, cert. ef. 5-27-92; FWC 6-1993, f. 1-28-93, cert. ef. 2-1-93; FWC 95-1994, f. 12-28-94, cert. ef. 1-1-95; FWC 45-1995, f. & cert. ef. 6-1-95; FWC 71-1996, f. 12-31-96, cert. ef. 1-1-97; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 32-2005(Temp), f. 4-29-05, cert. ef. 5-1-05 thru 10-27-05; DFW 70-2005, f. & cert. ef. 7-8-05; DFW 142-2008, f. & cert. ef. 11-21-08; DFW 156-2009, f. 12-29-09, cert. ef. 1-1-10; Renumbered from 635-004-0020, DFW 75-2012, f. 6-28-12; DFW 32-2013, f. & cert. ef. 5-14-13; DFW 136-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 4-2015, f. 1-13-15, cert. ef. 1-15-15; DFW 3-2016, f. & cert. ef. 1-19-16; DFW 149-2016, f. 12-7-16, cert. ef. 1-1-17

635-004-0223
Restrictions on Shared Ecosystem Component Species Applicable to All Commercial Fisheries

(1) Shared Ecosystem Component Species, as defined in OAR 635-004-0215, in the Pacific Ocean off Oregon are jointly managed by the state of Oregon and the federal government through the Pacific Fishery Management Council process. Therefore, the Code of Federal Regulations, Part 660, Subpart B, (October 1, 2016 ed.) is incorporated into Oregon Administrative Rule by reference. The Code of Federal Regulations provides federal requirements, including but not limited to prohibitions on directed fishing and at-sea processing for these species. For the purposes of this rule, directed fishing is defined as:

(a) Landing Shared Ecosystem Component Species without landing any other species;

(b) Landing more than 10 metric tons of Shared Ecosystem Componenent Species in aggregate from any fishing trip; or

(c) Landing more than 30 metric tons of Shared Ecosystem Component Species in aggregate within a calendar year.

(2) The geographical scope of those federal regulations cited in section (1) of this rule is hereby extended to the waters of this state from the head of tide of inland waters to three nautical miles offshore in the Pacific Ocean, except the Columbia River as defined in OAR 635-003-0005, and apply to fishing trips conducted from vessels entirely within these waters.

(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 635-004-0545 for additions or modifications to federal forage fish regulations.

[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 149-2016, f. 12-7-16, cert. ef. 1-1-17

635-005-0240
Definitions

As used in Division 005 regulations:

(1) "Animals living intertidally on the bottom" means any benthic animal with a natural range that includes intertidal areas, regardless of where harvest occurs, and includes but is not limited to, starfish, sea urchins, sea cucumbers, snails, bivalves, worms, coelenterates, and crabs except Dungeness crab.

(2) "Bait" means food fish not harvested for human consumption.

(3) "Board" means the Commercial Fishery Permit Board.

(4) "Buy" includes offer to buy, barter, exchange or trade.

(5) "Catastrophic loss" means direct loss of non-deployed gear in the event of a vessel being destroyed due to fire, capsizing, or sinking. Documentation of a catastrophic loss may include any information the Department considers appropriate, such as fire department or US Coast Guard reports.

(6) "Commercial landing cap" means the total landed catch of a given species, or species group, that may be taken in a single calendar year in Oregon commercial fisheries.

(7) "Commercial purposes" means taking food fish with any gear unlawful for angling, or taking or possessing food fish in excess of the limits permitted for personal use, or taking, fishing for, handling, processing, or otherwise disposing of or dealing in food fish with the intent of disposing of such food fish or parts thereof for profit, or by sale, barter or trade, in commercial channels, as specified in ORS 506.006.

(8) "Commission" means the State Fish and Wildlife Commission created by ORS 496.090.

(9) "Crab pot" means any portable, enclosed device used to take crab with one or more gates or entrances that allows crab restricted entry and exit, and has a line attached to surface floats.

(10) "Crab ring" means any fishing device used to take crab that allows crab unrestricted entry or exit while fishing, and has a line attached to surface floats.

(11) "Department" means the State Department of Fish and Wildlife.

(12) "Derelict Dungeness crab gear" means Dungeness crab gear which was lost, forgotten, damaged, abandoned or otherwise deserted.

(13) "Director" means the Director of the Oregon Department of Fish and Wildlife appointed pursuant to ORS 496.112.

(14) "Dive gear" means gear used while a fisher is submerged underwater in order to take food fish, and includes but is not limited to one or more of the following equipment: SCUBA or other surface supplied air source (hookah gear), dive mask, snorkel, air cylinders, weight belt, wetsuit and fins.

(15) "Dungeness crab gear" means crab pots, crab rings or a combination thereof used for taking Dungeness crab.

(16) "Exclusive Economic Zone" means the zone between 3-200 nautical miles offshore of the United States.

(17) "Fishing gear" means, as specified in ORS 506.006, any appliance or device intended for or capable of being used to take food fish for commercial purposes, and includes:

(a) "Fixed gear" means longline, trap or pot, set net, and stationary hook-and-line gears;

(b) "Gillnet" has the meaning as set forth in OAR 635-042-0010;

(c) "Hook-and-line" means one or more hooks attached to one or more lines;

(d) "Lampara net" means a surrounding or seine net with the sections of netting made and joined to create bagging, and is hauled with purse rings;

(e) "Longline" means a stationary buoyed, and anchored groundline with hooks attached;

(f) "Mesh size" means the opening between opposing knots. Minimum mesh size means the smallest distance allowed between the inside of one knot to the inside of the opposing knot regardless of twine size;

(g) "Pot or trap" means a portable, enclosed device with one or more gates or entrances and one or more lines attached to surface floats;

(h) "Purse seine" means an encircling net that may be closed by a purse line threaded through the bottom of the net. Purse seine gear includes ring net, drum purse seine, and lampara nets;

(i) "Seine" means any non-fixed net other than a trawl or gillnet and includes all types of purse seines;

(j) "Setline" means a bottom longline used in rivers and estuaries for targeting white sturgeon;

(k) "Set net" means a stationary, buoyed and anchored gillnet or trammel net which takes fish commonly by gilling and is not free to move or drift with the current or tide;

(l) "Spear" means a sharp, pointed, or barbed instrument on a shaft;

(m) "Trammel net" means a gillnet made with two or more walls joined to a common float line;

(n) "Trawl gear" means a cone or funnel-shaped net which is towed or drawn through the water by one or two vessels, and includes but is not limited to beam trawl, bobbin or roller trawl, bottom trawl, pelagic trawl and Danish and Scottish seine gear;

(o) "Troll" means fishing gear that consists of 1 or more lines that drag hooks with bait or lures behind a moving fishing vessel, and which lines are affixed to the vessel and are not disengaged from the vessel at any time during the fishing operation; and

(p) "Vertical hook and line" means a line attached to the vessel or to a surface buoy vertically suspended to the bottom by a weight or anchor, with hooks attached between its surface and bottom end.

(18) "Fishing trip" means a dock-to-dock transit during which fishing for commercial purposes occurs, and is followed by a landing.

(19) "Food Fish" means any animal over which the State Fish and Wildlife Commission has jurisdiction pursuant to ORS 506.036.

(20) "Groundfish" means all species of ocean food fish defined as groundfish in the Pacific Coast Groundfish Fishery Management Plan and in the Federal Groundfish Regulations, Title 50, Part 660 (See OAR 635-004-0240).

(21) "Intertidal" means the area in Oregon coastal bays, estuaries, and beaches between mean extreme low water and mean extreme high water boundaries.

(22) "Land, Landed or Landing" means either of the following:

(a) For fisheries where food fish were taken by use of a vessel, "land, landed or landing" means to begin transfer of food fish from a vessel. Once transfer begins, all food fish on board the vessel are counted as part of that landing, except anchovies being held live on a vessel for the purpose of using for bait in that vessel's commercial fishing operation; and

(b) For fisheries where food fish were taken without use of any vessel, "land, landed or landing" means to begin transfer of food fish from a harvester to a wholesale fish dealer, wholesale fish bait dealer, or food fish canner, under which the following provisions apply:

(A) When the harvester and the wholesale fish dealer, wholesale fish bait dealer, or food fish canner are the same person or entity, transfer occurs when the food fish arrive at the licensed premises of the wholesale fish dealer, wholesale fish bait dealer, or food fish canner; and

(B) Once transfer begins, all food fish from the harvest area are counted as part of that landing.

(23) "Length" or "Overall Length" of a vessel means the manufacturer's specification of overall length, United States Coast Guard or Marine Board registered length documentation stating overall length or overall length as surveyed by a certified marine surveyor. In determining overall length, marine surveyors shall measure in a straight line parallel to the keel from the foremost part of the vessel to the aftermost part, excluding sheer and excluding bow sprits, boomkins, rudders aft of the transom, outboard motor brackets, or transom extensions as in a dive step or platform.

(24) "Ocean Dungeness Crab fishing season" means the period normally from December 1 of one year through August 14 of the next year and is specific to the ocean Dungeness crab fishery. In periods where a season delay occurs, "ocean Dungeness crab fishing season" means from the date the fishery opens to the following August 14.

(25) "Oyster" includes oysters, oyster seed, oyster cultch, and oyster shell.

(26) "Pacific Ocean" means all water seaward of the end of the jetty or jetties of any river, bay, or tidal area, except the Columbia River boundary with the Pacific Ocean is as specified in OAR 635-003-0005, or all water seaward of the extension of the shoreline high watermark across the river, bay, or tidal area where no jetties exist.

(27) "Permit holder" means a person or entity that owns an individual permit or owns the vessel to which a vessel permit is attached. A lessee of a permit is not a permit holder.

(28) "Possession" means holding any food fish, shellfish or parts thereof in a person's custody or control.

(29) "Process or Processing" means fresh packaging requiring freezing of food fish, or any part thereof, or any type of smoking, reducing, loining, steaking, pickling or filleting. Cooking crab is not considered processing.

(30) "Replacement vessel" is a vessel purchased to replace a Limited Entry permitted vessel which has been lost due to fire, capsizing, sinking or other event.

(31) "Resident" means an actual bona fide resident of this state for at least one year, as specified in ORS 508.285.

(32) "Salmon" means all anadromous species of salmon, including but not limited to:

(a) Oncorhynchus gorbuscha, commonly known as humpback, humpies or pink salmon.

(b) Oncorhynchus keta, commonly known as chum or dog salmon.

(c) Oncorhynchus kisutch, commonly known as coho or silver salmon.

(d) Oncorhynchus nerka, commonly known as sockeye, red or blueback salmon.

(e) Oncorhynchus tshawytscha, commonly known as Chinook salmon.

(33) "Security interest" means an interest in a vessel or permit granted by the owner of the vessel or permit to a third party under a security agreement, pursuant to ORS chapter 79, another state's laws enacted to implement Article 9 of the Uniform Commercial Code or equivalent federal statutory provisions for federally documented vessels.

(34) "Sell" includes to offer or possess for sale, barter, exchange or trade.

(35) "Shared Ecosystem Component Species" means those ecosystem component species shared between all of the Pacific Fishery Management Council's Fishery Management Plans which occur in the Pacific Ocean off Oregon and include:

(a) Mesopelagic fishes of the families Myctophidae, Bathylagidae, Paralepididae, and Gonostomatidae;

(b) Pacific sand lance (Ammodytes hexapterus);

(c) Pacific saury (Cololabis saira);

(d) Silversides of the family Atherinopsidae;

(e) Smelts of the family Osmeridae; and

(f) Pelagic squids of the families Cranchiidae, Gonatidae, Histioteuthidae, Octopoteuthidae, Ommastrephidae except Humboldt squid (Dosidicus gigas), Onychoteuthidae, and Thysanoteuthidae.

(36) "Shellfish Sanitation Certificate" means a license required by Oregon Department of Agriculture to engage in business of harvesting, distributing or processing of oysters, clams, mussels and scallops for human consumption.

(37) "Special Regulation Marine Areas" means specific areas described in OAR 635-039-0090 and the "Oregon Sport Fishing Regulations," which includes all Marine Gardens, Subtidal Research Reserves, Intertidal Research Reserves, Habitat Refuges, and other areas closed to designated activities.

(38) "Take" means fish for, hunt, pursue, catch, capture or kill or attempt to fish for, hunt, pursue, catch, capture or kill.

(39) "Transport" means transport by any means, and includes offer or receive for transportation.

(40) "Trip limit" means the total amount of fish that may be taken and retained, possessed, or landed per vessel from a single fishing trip or cumulatively per unit of time. A vessel which has landed its cumulative or daily limit may continue to fish on the limit for the next legal period as long as the fish are not landed until the next period. Trip limits may be:

(a) "Bi-monthly cumulative trip limit" means the maximum amount of fish that may taken and retained, possessed or landed per vessel in specified bi-monthly periods. There is no limit on the number of landings or trips in each period, and periods apply to calendar months. The specified periods are as follows:

(A) Period 1: January through February;

(B) Period 2: March through April;

(C) Period 3: May through June;

(D) Period 4: July through August;

(E) Period 5: September through October; and

(F) Period 6: November through December.

(b) "Daily trip limit" means the maximum amount of shellfish that may be taken and retained, possessed or landed per vessel in 24 consecutive hours, starting at 00:01 hours local time;

(c) "Monthly trip limit" means the maximum amount of fish that may be taken and retained, possessed or landed per vessel during the first day through the last day of any calendar month.

(d) "Weekly trip limit" means the maximum amount of fish that may be taken and retained, possessed or landed per vessel in 7 consecutive days, starting at 00:01 hours local time on Sunday and ending at 24:00 hours local time on Saturday. Weekly trip limits may not be accumulated during multiple week trips. If a calendar week falls within two different months or two different cumulative limit periods, a vessel is not entitled to two separate weekly limits during that week.

(41) "Undue hardship" means death, serious illness requiring extended care by a physician, permanent disability, or other circumstances beyond the individual's control.

(42) "Unlawful to buy" means that it is unlawful to buy, knowing or having reasonable cause to believe that the fish have been illegally taken or transported within this state, or unlawfully imported or otherwise unlawfully brought into this state.

(43) "Vessel" means any floating craft, powered, towed, rowed or otherwise propelled which is used for landing or taking food fish for commercial purposes.

(44) "Vessel operator" means the person onboard a fishing vessel who is responsible for leading a fishing vessel in fishing or transit operations, and who signs the corresponding fish ticket from that fishing trip. A vessel operator may be a vessel owner or permit holder or both, individual hired to operate a vessel, or lessee of a vessel, permit or both. Although more than one person may physically operate a vessel during a fishing trip or transit, there may only be one person identified as a vessel operator (commonly referred to as a captain or skipper) on a fishing vessel during any one fishing trip or transit.

(45) "Vessel owner" means any ownership interest in a vessel, including interests arising from partnerships, corporations, limited liability corporations, or limited liability partnerships. A vessel owner does not include a leasehold interest.

(46) "Waters of this state" means all waters over which the State of Oregon has jurisdiction, or joint or other jurisdiction with any other state or government, including waters of the Pacific Ocean and all bays, inlets, lakes, rivers and streams within or forming the boundaries of this state.

Stat. Auth.: ORS 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109, 506.129 & 506.306
Hist.: FWC 30-1985, f. 6-27-85, ef. 7-1-85; FWC 137-1991(Temp), f. 12-20-91, cert. ef. 12-23-91; FWC 39-1992(Temp), f. & cert. ef. 6-19-92; DFW 61-2002, f. & cert. ef. 6-14-02; DFW 142-2008, f. & cert. ef. 11-21-08; Renumbered from 635-005-0001, DFW 76-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 149-2016, f. 12-7-16, cert. ef. 1-1-17

635-005-0263
Restrictions on Shared Ecosystem Component Species Applicable to All Commercial Fisheries

(1) Shared Ecosystem Component Species, as defined in OAR 635-004-0215, in the Pacific Ocean off Oregon are jointly managed by the state of Oregon and the federal government through the Pacific Fishery Management Council process. Therefore, the Code of Federal Regulations, Part 660, Subpart B, (October 1, 2016 ed.) is incorporated into Oregon Administrative Rule by reference. The Code of Federal Regulations provides federal requirements, including but not limited to prohibitions on directed fishing and at-sea processing for these species. For the purposes of this rule, directed fishing is defined as:

(a) Landing Shared Ecosystem Component Species without landing any other species;

(b) Landing more than 10 metric tons of Shared Ecosystem Componenent Species in aggregate from any fishing trip; or

(c) Landing more than 30 metric tons of Shared Ecosystem Component Species in aggregate within a calendar year.

(2) The geographic scope of those federal regulations cited in section (1) of this rule is hereby extended to the waters of this state from the head of tide of inland waters to three nautical miles offshore in the Pacific Ocean, except the Columbia River as defined in OAR 635-003-0005, and apply to fishing trips conducted from vessels entirely within these waters.

(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 635-005-0230 through 635-005-0275 and 635-004-0545 for additions or modifications to federal forage fish 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 149-2016, f. 12-7-16, cert. ef. 1-1-17

635-005-0915
Fishery Defined

"Squid fishery" means the commercial fisheries for squid species in the orders Myopsida, Oegopsida and Sepioidea, including, but not limited to market squid (*Loligo opalescens*) and Humboldt squid (*Dosidicus gigas*). Some squid species classified within these orders are managed as Shared Ecosystem Component Species, for which directed fishing is prohibited. See OAR 635-005-0263 and the Code of Federal Regulations, Part 660, Subpart B for regulations applicable to Shared Ecosystem Component Species.

Stat. Auth.: ORS 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 76-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 149-2016, f. 12-7-16, cert. ef. 1-1-17

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 subsequently submitted to ODFW. Fish dealers shall be required to account for all Fish Receiving Tickets received from the Department. Fish Receiving Tickets shall be issued 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 those fish or shellfish with no commercial value.

(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) 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; DFW 149-2016, f. 12-7-16, cert. ef. 1-1-17

Rule Caption: Commercial Dungeness Crab Season Opens on the South Coast.
Adm. Order No.: DFW 150-2016(Temp)
Filed with Sec. of State: 12-13-2016
Certified to be Effective: 12-18-16 thru 6-15-17
Notice Publication Date:
Rules Amended: 635-005-0465
Rules Suspended: 635-005-0465(T)
Subject: This amended rule sets the opening of the 2016-2017 ocean commercial Dungeness crab fishery from Cape Blanco (42º 50' 00" N. Lat.) southward to the Oregon-California border as December 18, 2016. The commercial Dungeness crab fishery will remain closed from north of Cape Blanco (42º 50' 00" N. Lat.) to the Oregon-Washington border due to elevated levels of the biotoxin domoic acid detected in tested samples.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-005-0465
Closed Season in Pacific Ocean and Columbia River

(1) It is unlawful to take, land or possess Dungeness crab for commercial purposes from the Pacific Ocean or Columbia River:

(a) In the area from Cape Blanco (42º 50' 00" N. Lat.) northward to the Oregon/Washington border (46°16'00" N. Lat.).

(b) In the area from Cape Blanco (42º 50' 00" N. Lat.) southward to the Oregon/California border (42°00'00") from August 15, 2016 through December 18, 2016 at 08:59 AM.

(2) The season opening for the commercial Ocean Dungeness crab fishery may be delayed in one or more fishing zones based on the results of crab quality or biotoxin testing. The Pre-season Testing Protocol for the Tri-State Coastal Dungeness crab Commercial Fishery (hereafter, "Tri-State Protocol") specifies the process for establishing fishing zones (section VI) and coordinating the opening of the fishery in Washington, Oregon, and California north of PointArena (sections IV and V). Therefore, the following sections of the Tri-State Protocol (Revised July 2014) are hereby incorporated into Oregon Administrative Rule by reference:

(a) Section IV — Season Opening Criteria.

(b) Section V — Test Fishing and Process for Setting the Season Opening Date.

(c) Section VI — Procedure for Establishing Fishing Zones. In the event that crab quality or biotoxin tests do not meet the criteria for opening the season on December 1, the Director shall adopt temporary rules delaying the season in accordance with the Tri-State Protocol. A vessel used for fishing crab in any open zone may not be used for fishing crab in any zone that opens at a later date until 30 days after the later opening date. The fisher must declare on the pre-season hold inspection certificate the zone in which the vessel will start fishing.

(3) It is unlawful to land, receive or buy, Dungeness crab in the first thirty days of the ocean Dungeness crab fishery from a vessel that has not been certified by officials of the State of Oregon, Washington, or California to have been free of Dungeness crab before fishing in the ocean Dungeness crab fishery. In the event the area between Gray's Harbor, Washington and Point Arena, California is divided into zones with different season opening dates, the ocean Dungeness crab fishery refers to the fishery in that zone for the purposes of this rule.

(4) Upon a determination by the Department that catch in Oregon's ocean Dungeness crab fishery after May 31 is greater than ten percent of the catch in the previous December 1 through May 31 period, the Director shall adopt a temporary rule closing the commercial season until the following December 1.

Stat. Auth.: ORS 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109, 506.129 & 506.306
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 285(74-20), f. 11-27-74, ef. 12-25-74; FC 293(75-6), f. 6-23-75, ef. 7-11-75; FWC 30, f. & ef. 11-28-75; FWC 132, f. & ef. 8-4-77; FWC 30-1985, f. 6-27-1985, ef. 7-1-85, Renumbered from 625-010-0155, Renumbered from 635-036-0125; FWC 56-1982, f. & ef. 8-27-82; FWC 13-1983, f. & ef. 3-24-83; FWC 39-1983(Temp), f. & ef. 8-31-83; FWC 11-1984, f. 3-30-84, ef. 9-16-84, except section (1) per FWC 45-1984, f. & ef. 8-30-84; FWC 30-1985, f. 6-27-85, ef. 7-1-85; FWC 78-1986(Temp), f. & ef. 12-1-86; FWC 36-1987, f. & ef. 7-1-87; FWC 97-1987(Temp), f. & ef. 11-17-87; FWC 102-1988, f. 11-29-88, cert. ef. 12-29-88; FWC 119-1989(Temp), f. 11-29-89, cert. ef. 12-1-89; FWC 135-1991(Temp), f. 12-10-91, cert. ef. 12-11-91; FWC 136-1991(Temp), f. & cert. ef. 12-19-91; FWC 112-1992, f. 10-26-92, cert. ef. 11-1-92; FWC 70-1993, f. 11-9-93, cert. ef. 11-11-93; FWC 88-1994(Temp), f. 11-30-94, cert. ef. 12-1-94; FWC 89-1994(Temp), f. & cert. ef. 12-1-94; FWC 89-1995(Temp), f. 11-28-95, cert. ef. 12-1-95; FWC 1-1996(Temp), f. 1-11-96, cert. ef. 1-13-96; DFW 51-1998(Temp), f. 6-29-98, cert. ef. 7-1-98 thru 9-15-98; DFW 54-1998(Temp), f. & cert. ef. 7-24-98 thru 9-15-98; DFW 40-1999, f. & cert. ef. 5-26-99; DFW 70-2000, f. & cert. ef. 10-23-00; DFW 77-2000(Temp), f. 11-27-00, cert. ef. 12-1-00 thru 12-14-00; DFW 39-2002, f. & cert. ef. 4-26-02; DFW 128-2002(Temp), f. & cert. ef. 11-15-02 thru 1-31-03; DFW 129-2002(Temp), f. & cert. ef. 11-20-02 thru 1-31-03; DFW 132-2002(Temp), f. & cert. ef. 11-25-02 thru 1-31-03 (Suspended by DFW 133-2002(Temp)); DFW 133-2002(Temp), f. & cert. ef. 12-6-02 thru 1-31-03; DFW 117-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 2-29-04; Administrative correction 10-26-04; DFW 113-2004(Temp), f. 11-23-04, cert. ef. 12-1-04 thru 3-1-05; DFW 116-2004(Temp), f. & cert. ef. 12-8-04 thru 3-1-05; DFW 126-2004(Temp), f. & cert. ef. 12-21-04 thru 3-1-05; DFW 132-2004(Temp), f. & cert ef. 12-30-04 thru 3-1-05; Administrative correction, 3-18-05; DFW 129-2005(Temp), f. & cert. ef. 11-29-05 thru 12-31-05; DFW 140-2005(Temp), f. 12-12-05, cert. ef. 12-30-05 thru 5-31-06; Administrative correction 7-20-06; DFW 142-2008, f. & cert. ef. 11-21-08; DFW 161-2010(Temp), f. 12-9-10, cert. ef. 12-10-10 thru 2-16-11; Administrative correction, 3-29-11; 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; Administrative correction 4-24-12; DFW 37-2012, f. 4-24-12, cert. ef. 5-1-12; Renumbered from 635-005-0045, DFW 76-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 145-2012(Temp), f. 11-14-12, cert. ef. 12-1-12 thru 12-31-12; DFW 146-2012(Temp), f. 12-11-12, cert. ef. 12-12-12 thru 6-9-13; Administrative correction, 6-27-13; DFW 118-2013, f. 10-11-13, cert. ef. 10-15-13; DFW 129-2013(Temp), f. 11-25-13, cert. ef. 12-1-13 thru 12-31-13; Administrative correction, 2-5-14; DFW 113-2014, f. 8-5-14, cert. ef. 8-15-14; DFW 157-2014(Temp), f. 11-24-14, cert. ef. 11-25-14 thru 5-23-15; Administrative correction, 6-23-15; DFW 150-2015, f. & cert. ef. 10-29-15; DFW 157-2015(Temp), f. & cert. ef. 11-20-15 thru 1-31-16; DFW 166-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; DFW 146-2016(Temp), f. & cert. ef. 11-23-16 thru 5-21-17; DFW 150-2016(Temp), f. 12-13-16, cert. ef. 12-18-16 thru 6-15-17

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Rule Caption: Tillamook Bay Commercial Cockle Clam Dive Fishery Closes.
Adm. Order No.: DFW 151-2016(Temp)
Filed with Sec. of State: 12-13-2016
Certified to be Effective: 12-15-16 thru 12-31-16
Notice Publication Date:
Rules Amended: 635-005-0355
Subject: This amended rule closes the Tillamook Bay commercial gaper clam dive fishery at 12:01 a.m. December 15, 2016 due to the projected attainment of the 235,000 pound annual harvest quota allowed under bay clam dive permits. Modifications are consistent with requirements described in OAR 635-005-0355 sections (1) and (2).
Rules Coordinator: Michelle Tate—(503) 947-6044

635-005-0355
Catch Limits

(1) In Tillamook Bay, the commercial landing cap for clams harvested by the bay clam dive fishery are 185,000 pounds for cockles, 235,000 pounds for gaper clams, and 225,000 pounds for butter clams.

(2) When any of the commercial clam landing caps specified in sections (1) of this rule are reached, the commercial cockle clam fishery in that particular estuary will close for the remainder of the calendar year.

(3) The Tillamook Bay gaper clam dive fishery is closed effective 12:01 a.m. Thursday, December 15, 2016, due to the anticipated attainment of the 235,000 pound landing cap.

Stat. Auth.: ORS 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 137-2005, f. 12-7-05, cert. ef. 1-1-06, Renumbered from 635-005-0032, DFW 76-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 80-2012(Temp), f. 6-28-12, cert. ef. 7-4-12 thru 12-30-12; Administrative correction, 2-1-13; DFW 54-2013(Temp), f. 6-12-13, cert. ef. 6-15-13 thru 12-11-13; Administrative correction, 12-19-13; DFW 69-2014(Temp), f. 6-12-14, cert. ef. 6-13-14 thru 12-10-14; Administrative correction, 12-18-14; DFW 11-2015(Temp), f. 2-3-15, cert. ef. 2-6-15 thru 7-31-15; Administrative correction, 8-18-15; DFW 112-2015(Temp), f. 8-20-15, cert. ef. 8-26-15 thru 12-31-15; DFW 164-2015, f. 12-9-15, cert. ef. 1-1-16; DFW 12-2016(Temp), f. 2-22-16, cert. ef. 2-23-16 thru 8-20-16; Administrative correction, 9-23-16; DFW 151-2016(Temp), f. 12-13-16, cert. ef. 12-15-16 thru 13-31-16

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Department of Human Services, Administrative Services Division and Director's Office
Chapter 407

Rule Caption: Changes to Investigation of Reported Abuse in Child-Caring Agencies due to SB1515 (2016)
Adm. Order No.: DHSD 8-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 10-1-2016
Rules Adopted: 407-045-0825, 407-045-0885, 407-045-0886, 407-045-0887, 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
Rules Repealed: 407-045-0810(T), 407-045-0830(T), 407-045-0850(T), 407-045-0860(T), 407-045-0870(T), 407-045-0880(T),

407-045-0900(T), 407-045-0920(T), 407-045-0930(T), 407-045-0960(T), 407-045-0970(T), 407-045-0980

Subject: The Department of Human Services (Department) is permanently adopting temporary rules that went into effect on July 1, 2016 to comply with SB 1515 (Oregon Laws 2016, chapter 2016). The law created new requirements relating to ensuring the safety of children and young adults residing in or receiving services from child-caring agencies licensed by the Department. The intent of this legislation is to enhance safety of children in child-caring agencies and proctor foster homes, align abuse definitions with paid caregiving expectations, define investigation outcomes, and improve communication within the Department.

The rules in OAR 407-045-0800 through 407-045-0980 outline the child-caring agencies or proctor foster homes in which the 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 abuse allegations in a child-caring agency or proctor foster home. Changes the definition of child in care to include young adults up to the age of 21 if they are residing in or receiving care or services from a child-caring agency or proctor foster homes and requires OAAPI investigators and screeners to notify appropriate Department personnel of the abuse report and investigation, and requires OAAPI to collaborate with appropriate personnel to share information and determine the appropriate Department response to ensure safety of the children in care.

In addition, non-substantive edits were made to these rules to ensure consistent terminology throughout Department 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: Jennifer Bittel—(503) 947-5250

407-045-0800
Purpose and Applicability

(1) The purpose of OAR 407-045-0800 to 407-045-0955 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).

(2) These rules govern reports of abuse or neglect in which the alleged victim is a child in care receiving services from a CCA and the accused is a proctor foster parent or one of the following CCA entities or an employee of that CCA, as defined in ORS 418.205 and regulated under OAR 413, division 215 as a:

(a) Residential care agency;

(b) Day treatment agency;

(c) Therapeutic boarding school;

(d) Foster care agency; or

(e) Outdoor youth program.

(3) Reported child abuse involving CCA entities not listed in section (2) of this rule, as well as by other accused persons not listed in that section must be screened and assessed for investigation by the Department's Child Welfare Program in accordance to OAR 413-015-0200 through 413-015-0225 and 413-015-0620 through 413-015-0640.

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; DHSD 8-2016, f. & cert. ef. 12-1-16

407-045-0820
Definitions

The following definitions apply to OAR 407-045-0800 through 407-045-0955:

(1) "Abuse" of a child in care means one or more of the following:

(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) 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, 163.465, 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 of 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 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.

(2) "Abuse" of a child in care also has the meaning given in ORS 419B.005.

(3) "Chemical restraint" meaning the administration of medication for the management of uncontrolled behavior. Chemical restraint is different from the use of medication for treatment of symptoms of severe emotional disturbances or disorders.

(4) "Child" means a person who is under 18 years of age.

(5) "Child in care" means an 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 to ORS 418.327, 418.470, 418.475, or 418.950 to 418.970.

(6) "Child-caring agency" (CCA) 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.

(7) "Financial exploitation" means:

(a) 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.

(8) "Department" means the Department of Human Services.

(9) "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.

(10) "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.

(11) "Intimidation" means compelling or deterring conduct by threat. Intimidation does not include age-appropriate discipline that may involve the threat to withhold privileges.

(12) "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 ORS 353.125.

(13) "Legal finding" means a court or administrative finding, judgment, order, stipulation, plea, or verdict.

(14) "Neglect" of a child in care 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.

(15) "OAAPI" means the Department's Office of Adult Abuse Prevention and Investigations.

(16) "OAAPI investigator" means a Department employee who is authorized and receives OAAPI approved training to screen or investigate allegation of abuse under these rules.

(17) "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.

(18) "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.

(19) "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.

(20) "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.

(21) "Screening" means the process used by the Department to determine the response when information alleging abuse or neglect is received.

(22) "Seclusion" means that a child in care is involuntarily confined to an area or room, and is physically prevented from leaving.

(23) "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.

(24) "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.

(25) "Sexual contact" has the meaning given that term in ORS 163.305(1)(a)(E).

(26) "Sexual exploitation" as described in ORS 419B.005(1)(a)(E).

(27) "Substantiated" means there is reasonable cause to believe that abuse of a child in care occurred.

(28) "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.

(29) "Unsubstantiated" means there is no evidence that the abuse of a child in care occurred.

(30) "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.: 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; DHSD 8-2016, f. & cert. ef. 12-1-16

407-045-0825

Screening Activities

(1) The OAAPI screener must ensure completion of the screening activities described below, if not already documented as completed by the Department's Office of Child Welfare.

(a) Gather the following information:

(A) The type of alleged abuse and the circumstances surrounding the report; and

(B) How the alleged abuse or the surrounding circumstances are reported to affect the safety of the child in care.

(b) Gather information from individuals who can provide firsthand information necessary to determine the appropriate Department response.

(c) Inquire regarding possible Indian or Alaskan Native heritage.

(d) Request relevant information when available and appropriate from law enforcement agencies.

(2) After completing the activities required in (1), the screener must determine the OAAPI response, either assign for investigation or close at screening. If an investigation is required, the screener must then determine the time line for the OAAPI response.

(a) An OAAPI investigation is required if the information received constitutes a report of abuse as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106 and all of the following apply:

(A) The CCA is listed in OAR 407-045-0800(2) or is a CCA certified proctor foster home;

(B) 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; and

(C) The alleged victim of abuse is receiving services as a child in care as defined by OAR 407-045-0820.

(b) The screener must also determine the response time for the assigned OAAPI investigator as:

(A) A within 24 hours response time line is required unless (B) of this subsection applies.

(B) A within five days response time line must only be used when the screener can clearly document how the information indicates the child in care'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 in care.

(C) An OAAPI supervisor may change the response time line. When changing from a within 24 hours to within five days, the supervisor must explain in writing why the time line was changed and how safety was considered when the change was approved.

(c) A report will be closed at screening if the screener determines the information does not meet the conditions listed in section (2a) of this rule. Supervisor approval is required prior to closing a report at screening.

(3) The screener must document screening activities completed and the information supporting the decision to either assign or close a report at screening.

(4) OAAPI must collaborate with law enforcement and Department personnel or other appropriate entities to ensure child safety is provided.

(5) OAAPI must make all applicable cross reports and notifications as described in OAR 407-045-0895 and must send the screening decision report to the Department personnel designated to make notifications required by Oregon Laws 2016, chapter 106 and OAR 413-080-0070.

(6) 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 in care's location, is still needed to determine the Department response. The screener must 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; DHSD 8-2016, f. & cert. ef. 12-1-16

407-045-0885
Investigating Reports of Abuse

(1) In conducting abuse investigations, the OAAPI investigator or designee must attempt and, when possible, complete the following:

(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, unless the screener documents a five day response time line per OAR 407-045-0825(2)(b)(B).

(b) Collaborate with law enforcement, Department personnel or other appropriate entities to ensure child safety.

(c) 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 must conduct in-person interviews where practicable.

(d) Inform persons being interviewed that they may decline to be interviewed and conduct interviews in a place and manner that allows them to leave or terminate the interview at any time.

(e) 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.

(A) Prior to interviewing any child in care, OAAPI 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.

(B) When OAAPI interviews a child in care, the child must 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.

(C) If OAAPI determines contact with the child in care should occur at the child's school, OAAPI must comply with the requirements of ORS 419B.045.

(f) 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 home; and

(B) 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.

(g) Take photographs as appropriate or necessary.

(2) If the investigator observes a child in care who has suffered a suspicious physical injury and the investigator is certain or has a reasonable suspicion that the injury is or may be the result of abuse, the investigator must pursuant to ORS 419B.023, in accordance with the protocols and procedures of the county multidisciplinary child abuse team described in ORS 418.747:

(a) Immediately photograph or cause to 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) 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, unless the child is age 18 or older and exercises their right to decline. If a designated medical professional is not available to conduct a medical assessment within 48 hours, the investigator must ensure that an available physician, physician's assistant or nurse practitioner conducts the medical assessment. The investigator must document the efforts made to locate the designated medical professional.

(A) The investigator must facilitate an assessment by a medical professional if the alleged abuse involves injury to the anal or genital region.

(B) When there are indications of severe physical trauma to the child in care, the investigator must make arrangements to immediately transport the child in care to a medical facility, which may include calling 911. The investigator must also make arrangements for medical examination of a child in care for mild or moderate physical trauma. To make arrangements for the medical examination of a child in care, the investigator must work with the Department's Child Welfare Program to assure OAR 413-015-0415(10)(e) to (i) occurs.

(C) When the investigator determines that the child in care is in need of a medical assessment as part of an abuse investigation, the investigator must consult with an OAAPI supervisor as soon as possible, but not at the expense of delaying medical treatment.

(D) As provided in ORS 147.425, a child in care who is the alleged victim of a person crime and at least 15 years old at the time of the alleged abuse may have a personal representative present during a medical examination.

(i) The personal representative needs to be over 18 years old and is selected by the child in care who is the alleged victim.

(ii) The personal representative may not be a person who is a suspect in, a party to or witness to, the crime.

(iii) If an investigator believes that a personal representative would compromise the abuse investigation, an investigator may prohibit a personal representative from being present during the medical examination.

(3) A law enforcement officer, child welfare worker or the OAAPI investigator may take photographs for the purpose of documenting the child in care's condition at the time of the abuse investigation as required in subsection (2)(a) of this section. Photographs of the anal or genital region may be taken only by medical personnel.

(a) The OAAPI investigator will photograph or cause to be photographed any suspicious injuries if the investigator is certain or has a reasonable suspicion the suspicious injuries are the result of abuse regardless of whether the child in care has previously been photographed or assessed during an abuse investigation:

(A) During the investigation of a new allegation of abuse; and

(B) Each time, during the investigation, an injury is observed that was not previously observed by the assigned investigator.

(b) When a child in care is photographed pursuant to this section, 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:

(A) 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

(B) 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, name of the child in care, and date taken.

(C) 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 in care's case.

(D) Whenever an OAAPI investigator takes photographs of physical injuries of a child in care who is in the custody of the Department, the investigator must 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 must cooperate with the law enforcement agency. When a law enforcement agency is conducting a criminal investigation of the alleged abuse, OAAPI must 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 must 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 must issue a final abuse investigation report as described in OAR 407-045-0890 stating whether the allegation is substantiated, unsubstantiated or inconclusive and explain the basis for that determination.

(7) Any deviations from the investigative process must be staffed and approved by a supervisor. Deviations and approval must be documented clearly in the investigative report.

(8) 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.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 investigator must 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; DHSD 8-2016, f. & cert. ef. 12-1-16

407-045-0886
Exception to Completing Investigation

(1) The only exception to completing the investigation required by these rules per OAR 407-045-0885 on an assigned case is when an OAAPI investigator, in consultation with a supervisor, determines prior to the initial contact that the referral does not require an investigation under these rules because:

(a) The investigation was opened in error; or

(b) There is no longer an allegation of abuse or neglect. The investigator received information after being assigned the case that information in combination with the corresponding screening report no longer constitutes a report of child abuse as defined in ORS 419B.005 or OAR 407-045-0820. This exception may be used only when the investigator and the supervisor determine the information:

(A) Relates directly to and specifically negates all allegations in the screening report; and

(B) 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 an investigation must be completed when the investigator has already made contact with the alleged victim, unless the alleged victim is the original reporter.

(3) The investigator must document the determination and explain the basis for the determination that an OAAPI abuse investigation is not necessary. The documentation must include the name of the supervisor who was consulted and approved the change.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: 419B.005-419B.050 & OL 2016, chapter 106
Hist.: DHSD 8-2016, f. & cert. ef. 12-1-16

407-045-0887
Abuse Determination

(1) After gathering all the information necessary to complete the abuse investigation, the investigator must determine if there is reasonable cause to believe that abuse of a child in care occurred as defined in ORS 419B.005 or OAR 407-045-0820.

(2) The possible abuse of a child in care determinations are:

(a) "Substantiated" which means there is reasonable cause to believe that abuse of a child in care occurred.

(b) "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.

(c) "Unsubstantiated" which means there is no evidence that the abuse of a child in care occurred.

(3) When determining whether there is reasonable cause to believe abuse occurred, the investigator must consider the behavior, conditions, and circumstances in the definition of abuse described in OAR 407-045-0820 or ORS 419B.005.

(4) When a determination whether abuse occurred is made, OAAPI must ensure the completed investigation report described in OAR 407-045-0890 is sent to the Department personnel assigned to ensure notifications required by Oregon Laws 2016, chapter 106.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: 419B.005-419B.050 & OL 2016, chapter 106
Hist.: DHSD 8-2016, f. & cert. ef. 12-1-16

407-045-0890
Abuse Investigation Report

(1) The OAAPI investigator must 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 a conclusion concerning the allegation of abuse;

(d) A specific finding of whether the abuse allegation is substantiated, unsubstantiated or inconclusive and the basis for that determination;

(e) A list of all individuals and entities who receive the required notices as described in OAR 407-045-0895;

(f) The name and title of the individual completing the report; and

(g) Documentation that a supervisor has reviewed and approved the completed report.

(2) The report must be completed within 30 business days from the date the case was assigned for investigation unless an extension of time is approved.

(3) The OAAPI Director or designee may authorize an extension of time for good cause shown, such as the ability to obtain critical information is beyond the reasonable control of the investigator.

(a) Documentation of the date of the extension must be noted in the completed report.

(b) The investigator must ensure notification of the approved extension and the new due date for the report's completion is provided to:

(A) The contact person for the involved CCA, and

(B) Those who received notification of the opened OAAPI investigation per OAR 413-080-0070.

(4) The supervisor must review and approve the completed report within one week of the submission of the report for approval.

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. 7-1-10; DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16; DHSD 8-2016, f. & cert. ef. 12-1-16

407-045-0895
Cross Reporting and Notifications

(1) The screener or investigator, if information is received during screening activities or investigation, must immediately report to law enforcement:

(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 must 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 must cross-report a second time 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, the screener or investigator will make diligent efforts to contact the reporter if contact information was provided to notify the reporter per ORS 419B.020(8) of the following:

(a) Whether contact was made with the child in care;

(b) Whether the Department determined that child abuse or neglect occurred; and

(c) Whether services were provided.

(3) If the OAAPI screener or investigator becomes aware a person accused of abuse is licensed or certified by a public agency or board, OAAPI must provide written notification of the abuse investigation being conducted under these rules to the public agency or board that license or certifies the person accused practicing in the CCA.

(4) If the screener or investigator knows or has reason to know that the child is an Indian child, the screener or investigator shall ensure notice is given within 24 hours to the Indian child's tribe that an investigation is being conducted.

(5) The Department must 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; DHSD 8-2016, f. & cert. ef. 12-1-16

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 must deliver a notice to the person with substantiated abuse or CCA named in the report. The notice must 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 must be addressed to the person with substantiated abuse or to the OAAPI contact on record for a CCA and a copy of the notice must 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 must 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 and may meet with the OSRC in person;

(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 must 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 others associated with the person with substantiated abuse or CCA, or with others mentioned in the report; or conduct a field assessment or investigation of the allegation of abuse; and

(k) A statement that OAAPI must 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 must 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 must:

(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 must document the telephone call.

(c) If no return receipt exists or if it appears that notice was not properly provided, OAAPI must 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 must 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 must 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; DHSD 8-2016, f. & cert. ef. 12-1-16

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 by the OSRC. The OSRC must 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.

(2) A person with substantiated abuse or CCA requesting a review must use information contained in the notice of OAAPI substantiation to either meet with the OSRC or prepare a written request for review. The written request for review must 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 must be postmarked within 30 calendar days. The request must 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 must 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 must operate as follows:

(a) The OSRC must 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 others associated with the person with substantiated abuse or CCA, or with others mentioned in the report; or conduct a field assessment or investigation of the allegation of abuse.

(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 must 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 must decide to either uphold the OAAPI substantiation, or change that conclusion to unsubstantiated or inconclusive.

(5) OSRC must 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 must 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; DHSD 8-2016, f. & cert. ef. 12-1-16

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 must 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 must 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; DHSD 8-2016, f. & cert. ef. 12-1-16

407-045-0955
Confidentiality

(1) The report and underlying investigatory documents are confidential and not available for public inspection except may be disclosed as provided in ORS 419B.035. The name and identifying information about the person who reported abuse may not be disclosed.

(a) 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.

(b) The Department must make otherwise confidential records available to individuals identified in ORS 419B.035(1), and may release records if permitted by ORS 419B.035(3) whenever such disclosure:

(i) Is necessary for administration of child welfare services and is in the best interests of the child in care;

(ii) Is necessary to investigate, prevent or treat child abuse; or

(iii) To protect children generally from abuse.

(2) Except as provided in section (1) of this rule, the Department must 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 or to any person who was determined 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 must 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; DHSD 8-2016, f. & cert. ef. 12-1-16

Rule Caption: Child Abuse Checks on Providers; Other Rule Corrections and Updates
Adm. Order No.: DHSD 9-2016
Filed with Sec. of State: 12-1-2016
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Rules Amended: 407-007-0210, 407-007-0250, 407-007-0279, 407-007-0290, 407-007-0320, 407-007-0330
Rules Repealed: 407-007-0210(T), 407-007-0250(T), 407-007-0279(T), 407-007-0290(T), 407-007-0320(T), 407-007-0330(T)
Subject: Oregon Laws 2016, chapter 106, section 6 (2016 SB1515) became effective 7/1/2016, adding requirements regarding proctor foster parents applying for certification or recertification through a child-caring agency. These requirements were added to the rules on 7/1/2016; the current rulemaking makes those changes permanent. The requirements include:

The addition of disclosure language needed in the background check request allows 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 as potentially disqualifying.

The addition of the making of a 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 amendments were added to the rules on 7/1/2016; the current rulemaking makes those amendments permanent. The amendments 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.

Amendments to OAR 407-007-0290 broaden the abuse check on Department of Human Services' providers to include a check of child abuse records and all other SIs if in their position they will have direct contact with children. Any substantiated child abuse against these SIs will be considered potentially disqualifying and require a weighing test under these provider rules.

Other updates include clarification to rules language, error corrections and alignment with current processes.
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) "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.

(3) "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.

(4) "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.

(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, nonprof-

it, 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 approved SI appointed by the QE's appointing authority to handle background checks on behalf of the QE.

(7) "QE Initiator (QEI)" means an approved SI to whom 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 child foster homes licensed by the Department's DD programs, or child foster or adoptive homes governed by OAR chapter 413 division 215:

(i) A foster parent or proctor foster parent;

(ii) An adoptive parent applicant or an approved adoptive parent;

(iii) A household member in an adoptive or foster home 18 years of age and over;

(iv) A household member in an adoptive or 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; and

(v) A respite care provider.

(H) An individual with contact with clients, client information, or client funds, who is an employee, contractor, or volunteer for a child-caring agency 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 a 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 and OAR 409-030-0100 to 409-030-0250.

(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)-(E) 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) Volunteers providing any care or services for a QE's special event lasting no more than 2 weeks whose access to clients is no more than three days within the two-week period. These volunteers must always be actively supervised in accordance with OAR 407-007-0315 and have no unsupervised contact with clients.

(F) Individuals employed by a private business that provides services to clients and the general public and is not regulated by the Department or Authority.

(G) 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.

(H) 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.

(I) 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.

(J) Employees, contractors, students, interns, and volunteers working in home health agencies, in-home care agencies, or hospice programs as defined by the Authority in administrative rule.

(K) Volunteers, who are not under the direction and control of a licensed, certified, registered, or otherwise regulated QE.

(L) Individuals employed or volunteering in a Medicare-certified health care business which is not subject to licensure or certification by the State of Oregon.

(M) Individuals working in restaurants or at public swimming pools.

(N) Hemodialysis technicians.

(O) 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.

(P) Individuals working for a transit service provider which conducts background checks pursuant to ORS 267.237.

(Q) Emergency medical technicians and first responders certified by the Authority's Emergency Medical Services and Trauma Systems program.

(R) Employees, contractors, temporary workers, or volunteers of continuing care retirement communities registered under OAR chapter 411, division 67.

(S) Individuals hired by or on behalf of a resident in a QE to provide care privately to the resident.

(T) An employee, contractor, temporary worker, or volunteer who provides care or has access to specific 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; DHSD 9-2016, f. & cert. ef. 12-1-16

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) Position title and description of duties to be considered;

(b) Indication of the SI's direct contact with any of the following:

(A) Children (for a child-caring agency governed by OAR chapter 413 division 215, children includes an individual who is under 21 years of age who is residing in or receiving care or services);

(B) Adults;

(C) Seniors (65 years and older);

(D) Confidential information;

(E) Secure Facilities;

(F) Finances or financial records; or

(G) Information Technology Systems.

(c) Worksite location or locations where the SI will be working;

(d) 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.

(e) 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.

(f) For an SI who is a 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 against the SI.

(B) The SI must also disclose:

(i) Any currently open or pending child or adult protective services abuse investigations;

(ii) Any substantiations of child or adult abuse allegations; and

(iii) Any restraining order or protective orders 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 against the SI.

(iii) Confirmation of the SI being certified or licensed by the Department as a child foster home parent.

(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 three years from the date of the current background check request. 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 result 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) If BCU determines that an SI has additional potentially disqualifying convictions or conditions which have occurred after receiving the background check request, 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 final fitness determination.

(10) 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 final fitness determination.

(11) 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; DHSD 9-2016, f. & cert. ef. 12-1-16

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 final fitness determination. If the convictions and conditions under 42 USC 1320a-7(a) occurred after five years from the date the final fitness determination, 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) A home care worker or personal support worker as defined in ORS 410.600; or

(B) 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 an SI who is 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; DHSD 9-2016, f. & cert. ef. 12-1-16

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 of the final fitness determination unless otherwise noted:

(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 as a level three sex offender under ORS 163A.100(3), a predatory sex offender prior to January 1, 2014, or found to be a sexually violent dangerous offender under ORS 144.635 (or similar designations 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 final fitness determination.

(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 of the final fitness determination.

(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 an SI associated with child foster homes licensed by the Department's DD programs, or child foster or adoptive homes governed by OAR chapter 413 division 215:

(A) Child protective services history held or received 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 an SI on the background check registry maintained under OAR 407-007-0600 to 407-007-0640; licensed, certified, or otherwise regulated by the Department; associated with any QE licensed, certified, or otherwise regulated by the Department (any QE licensed, certified, or regulated only with the Authority and not the Department are not included):

(A) Child protective services history held or received 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 the OAAPI and APD programs based on severity.

(c) For any other SI with direct contact with children:

(A) Child protective services history held or received 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 the OAAPI and APD programs based on severity.

(d) For all other SIs, 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) For an SI who is a 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.

(13) For an SI who is a proctor foster parent, the SI has any restraining order or protective order against the SI.

(14) For an SI who is SI who is a 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; DHSD 9-2016, f. & cert. ef. 12-1-16

407-007-0320

Final Fitness Determinations

(1) A final fitness determination pursuant to OAR 125-007-0260 and these rules will be made after all necessary background checks have been received and a weighing test, if necessary, has been completed. For the purpose of a final fitness determination as defined in OAR 407-007-0010(18), an authorized designee includes:

(a) A BCU staff trained to make a final fitness determination;

(b) A BCU hearing representative if a fitness determination is contested under OAR 407-007-0330, 407-007-0335, or 943-007-0501; or

(c) An administrative law judge if a contested fitness determination results under a contested case hearing through the Office of Administrative Hearings.

(2) The final fitness determination results in one of the following outcomes:

(a) The authorized designee 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, the authorized designee determines that more likely than not, the SI poses no risk to the physical, emotional, or financial well-being of vulnerable individuals.

(b) The authorized designee may approve an SI with restrictions if the SI has potentially disqualifying convictions or potentially disqualifying conditions and, after a weighing test, the authorized designee 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) The authorized designee shall deny an SI if the SI has potentially disqualifying convictions or potentially disqualifying conditions and, after a weighing test, the authorized designee determines more likely than not the SI 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 background 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 who is a proctor foster parent and fails to provide a release of information, the background check request is considered closed.

(G) BCU determines that the final fitness determination is mandatory exclusion due to the SI being subject to OAR 407-007-0279 and having a conviction or condition listed in OAR 407-007-0279, the background check request is considered completed. The SI has hearing rights only if granted under federal law.

(e) BCU shall issue an intent to deny if the final fitness determination meets the criteria in OAR 407-007-0335(1). The SI has expedited hearings rights under OAR 407-007-0335.

(3) 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 Intent to Deny and provide the SI hearing rights under OAR 407-007-0335.

(c) Except as required by section (3)(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.

(4) BCU shall provide the QE notification of the final fitness determination when the SI is being denied or approved with restrictions.

(5) 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 back-

ground 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.

(6) 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.

(7) BCU shall maintain any documents obtained or created during the background check process.

(8) 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; DHSD 9-2016, f. & cert. ef. 12-1-16

407-007-0330

Contesting a Fitness Determination

(1) An SI may contest a final fitness determination of denied or restricted approval pursuant to OAR 125-007-0300 unless already granted contested case hearing rights under OAR 407-007-0335.

(2) If an SI is determined to have a mandatory exclusion pursuant to federal law and OAR 407-007-0279, the SI may have hearing rights only if allowed by federal law.

(3) If an SI is denied, the SI may not hold the position, provide services or be employed, licensed, certified, or registered, or otherwise perform in positions covered by these rules. An SI appealing a restricted approval may only work under the terms of the restriction during the appeal.

(4) If an adverse outcome is changed at any time during the appeal process, the change does not guarantee employment or placement.

(5) An SI may represent himself or herself or have legal representation during the appeal process. For the purpose of this rule, the term "SI" shall be considered to include the SI's legal representative.

(a) An SI who is appealing an adverse outcome regarding the position of homecare worker as defined in ORS 410.600 or personal support worker as defined in ORS 410.600 may be represented by a labor union representative pursuant to ORS 183.459.

(b) For all other SIs, the SI may not be represented by a lay person.

(6) An SI may contest an adverse fitness determination by requesting a contested case hearing. The contested case hearing process is conducted in accordance with OAR 125-007-0300, ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings (OAH), OAR 137-003-0501 to 137-003-0700.

(a) To request a contested case hearing, the SI shall complete and sign the Hearing Request form.

(b) The completed and signed form must be received by the Department within 45 calendar days after the effective date of action.

(c) BCU shall accept a properly addressed hearing request that was not timely filed if it was postmarked within the time specified for timely filing.

(d) In the event an appeal is not timely by the date of receipt or by the date of postmark, BCU shall determine, based on a written statement from the SI and available information, if there is good cause to proceed with the appeal.

(e) BCU may refer an untimely request to the OAH for a hearing on the issue of timeliness.

(7) BCU may conduct an administrative review before referring the appeal to the OAH.

(a) The SI must participate in the administrative review. Participation may include but is not limited to providing additional information or additional documents requested by the BCU within a specified amount of time.

(b) The administrative review is not open to the public.

(8) BCU may conduct additional criminal records checks or abuse checks during the contested case hearing process to update or verify the SI's potentially disqualifying convictions or conditions and factors to consider in the weighing test. If BCU finds new potentially disqualifying convictions and conditions during the administrative review, BCU shall make a new final fitness determination and amend the notice of fitness determination while still maintaining the original hearing rights and deadlines.

(9) The Department shall be represented by a hearing representative in contested case hearings. The Department may also be represented by the Office of the Attorney General.

(a) The administrative law judge shall make a new final fitness determination based on evidence and the contested case hearing record.

(b) The only remedy an administrative law judge may grant is a final fitness determination that the SI is approved, approved with restrictions, or denied. Under no circumstances shall the Department or the QE be required to place an SI in any position, nor shall the Department or the QE be required to accept services or enter into a contractual agreement with an SI.

(10) The notice of final fitness determination issued is final as if the SI never requested a hearing in the following situations:

(a) The SI failed to request a hearing in the time allotted in this rule. No other document will be issued after the notice of final fitness determination.

(b) The SI withdraws the request for hearing at any time during the appeal process.

(11) BCU may make an informal disposition based on the administrative review. The Department shall issue a final order and new notice of final fitness determination. If the resulting fitness determination is an adverse outcome, the appeal shall proceed to a contested case hearing.

(12) BCU shall issue a dismissal order in the following situations:

(a) The SI may withdraw a hearing request verbally or in writing at any time before the issuance of a final order. A dismissal order due to the withdrawal is effective the date the withdrawal is received by BCU or the OAH. The SI may cancel the withdrawal in writing within 14 calendar days after the date of withdrawal.

(b) BCU shall dismiss a hearing request when the SI fails to participate in the administrative review. Failure to participate in the administrative review shall result in termination of hearing rights. The order is effective on the due date for participation in the administrative review. BCU shall review a good cause request to reinstate hearing rights if received in writing by BCU within 14 calendar days.

(c) BCU shall dismiss a hearing request when the SI fails to appear at the time and place specified for the contested case hearing. The order is effective on the date scheduled for the hearing. BCU shall review a good cause request to reinstate hearing rights if received in writing by BCU within 14 calendar days of the order.

(13) After a hearing, the administrative law judge shall issue a proposed and final order.

(a) If no written exceptions are received by BCU within 14 calendar days after the service of the proposed and final order, the proposed and final order becomes the final order.

(b) If timely written exceptions to the proposed and final order are received by BCU, the Department's Director or designee shall consider the exceptions and serve a final order, or request a written response or a revised proposed and final order from the administrative law judge.

(14) Final orders, including dismissal and default orders, are subject to reconsideration or rehearing petitions within 60 calendar days after the order is served, pursuant to OAR 137-003-0675.

(15) BCU may provide the QED with the results of the appeal.

Stat. Auth.: ORS 181A.200, 183.459, 409.027 & 409.050

Stats. Implemented: ORS 181A.195, 181A.200, 183.459, 409.010, 409.027 & 443.004

Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04; OMAP 22-2005, f. & cert. ef. 3-29-05; Renumbered from 410-007-0330, DHSD 8-2007, f. 8-31-07, cert. ef. 9-1-07; 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 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 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 9-2016, f. & cert. ef. 12-1-16

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

Rule Caption: Rate Schedule for Home and Community-Based Services
Adm. Order No.: APD 41-2016
Filed with Sec. of State: 12-2-2016
Certified to be Effective: 12-28-16

Notice Publication Date: 11-1-2016
Rules Amended: 411-027-0170
Subject: The Department of Human Services (Department) is permanently updating OAR 411-027-0170 to make permanent temporary changes that became effective July 1, 2016 that revised the home and community based care facility rates. These rates are being updated to be consistent with the current rate table information. The new rates became 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; APD 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; APD 41-2016, f. 12-2-16, cert. ef. 12-28-16

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Department of Human Services, Child Welfare Programs
Chapter 413

Rule Caption: Implementation of SB 1515 (2016)
Adm. Order No.: CWP 22-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 11-1-2016
Rules Adopted: 413-215-0000, 413-215-0218, 413-215-0318, 413-215-0618
Rules Amended: 413-215-0001, 413-215-0011, 413-215-0016, 413-215-0021, 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, 413-215-0101, 413-215-0106, 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, 413-215-0526, 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, 413-215-0996, 413-215-1001, 413-215-1006, 413-215-1011, 413-215-1016, 413-215-1021, 413-215-1026, 413-215-1031, 413-010-0000, 413-010-0500, 413-010-0502, 413-010-0505, 413-010-0510, 413-010-0525, 413-010-0535, 413-215-0026, 413-215-0111, 413-215-0521, 413-215-0992
Rules Repealed: 413-215-0000(T), 413-215-0001(T), 413-215-0006, 413-215-0011(T), 413-215-0016(T), 413-215-0021(T), 413-215-0026(T), 413-215-0031(T), 413-215-0036(T), 413-215-0041(T), 413-215-0046(T), 413-215-0051(T), 413-215-0056(T), 413-215-0061(T), 413-215-0066(T), 413-215-0071(T), 413-215-0076(T), 413-215-0081(T), 413-215-0086(T), 413-215-0091(T), 413-215-0096, 413-215-0101(T), 413-215-0106(T), 413-215-0111(T), 413-215-0116(T), 413-215-0121(T), 413-215-0126(T), 413-215-0131(T), 413-215-0201(T), 413-215-0206, 413-215-0211(T), 413-215-0216(T), 413-215-0221(T), 413-215-0226(T), 413-215-0231(T), 413-215-0236(T), 413-215-0241(T), 413-215-0246(T), 413-215-0251(T), 413-215-0256, 413-215-0261(T), 413-215-0266(T), 413-215-0271(T), 413-215-0276(T), 413-215-0301(T), 413-215-0306, 413-215-0311(T), 413-215-0313(T), 413-215-0316(T), 413-215-0321(T), 413-215-0326(T), 413-215-0331(T), 413-215-0336(T), 413-215-0341(T), 413-215-0346, 413-215-0349(T), 413-215-0351(T), 413-215-0356(T), 413-215-0361(T), 413-215-0366(T), 413-215-0371(T), 413-215-0376(T), 413-215-0381(T), 413-215-0386(T), 413-215-0391(T), 413-215-0396(T), 413-215-0401(T), 413-215-0406, 413-215-0411(T), 413-215-0416(T), 413-215-0421(T), 413-215-0426(T), 413-215-0431(T), 413-215-0436(T), 413-215-0441(T), 413-215-0446(T), 413-215-0451(T), 413-215-0456(T), 413-215-0461(T), 413-215-0466(T), 413-215-0471(T), 413-215-0476(T), 413-215-0481(T), 413-215-0501(T), 413-215-0506, 413-215-0511(T), 413-215-0516(T), 413-215-0521(T), 413-215-0526(T), 413-215-0531(T), 413-215-0536(T), 413-215-0541(T), 413-215-0546(T), 413-215-0551(T), 413-215-0554(T), 413-215-0556(T), 413-215-0561(T), 413-215-0566(T), 413-215-0571(T), 413-215-0576(T), 413-215-0581(T), 413-215-0586(T), 413-215-0601(T), 413-215-0606, 413-215-0611(T), 413-215-0616(T), 413-215-0621(T), 413-215-0626(T), 413-215-0631(T), 413-215-0636(T), 413-215-0641(T), 413-215-0646(T), 413-215-0651(T), 413-215-0656(T), 413-215-0661(T), 413-215-0666(T), 413-215-0671(T), 413-215-0676(T), 413-215-0681(T), 413-215-0701(T), 413-215-0706, 413-215-0711(T), 413-215-0716(T), 413-215-0721(T), 413-215-0726(T), 413-215-0731(T), 413-215-0736(T), 413-215-0741(T), 413-215-0746(T), 413-215-0751(T), 413-215-0756(T), 413-215-0761(T), 413-215-0766(T), 413-215-0801(T), 413-215-0806, 413-215-0811(T), 413-215-0816(T), 413-215-0821(T), 413-215-0826(T), 413-215-0831(T), 413-215-0836(T), 413-215-0841(T), 413-215-0846(T), 413-215-0851(T), 413-215-0856(T), 413-215-0901(T), 413-215-0906, 413-215-0911, 413-215-0916(T), 413-215-0921(T), 413-215-0926(T), 413-215-0931(T), 413-215-0936(T), 413-215-0941(T), 413-215-0946(T), 413-215-0951(T), 413-215-0956(T), 413-215-0961(T), 413-215-0966(T), 413-215-0971(T), 413-215-0976(T), 413-215-0981(T), 413-215-0986(T), 413-215-0991(T), 413-215-0992(T), 413-215-0996(T), 413-215-1001(T), 413-215-1006(T), 413-215-1011(T), 413-215-1016(T), 413-215-1021(T), 413-215-1026(T), 413-215-1031(T), 413-010-0501
Subject: The Department is adopting and amending rules to address gaps and improve the oversight by the Department of child-caring

agencies, establish and implement new Department oversight requirements and enforcement authority including taking action on licensing violations and deficiencies, promote the safety and well-being of children residing in or receiving services from child-caring agencies licensed by the Department and proctor foster homes, and comply with and implement SB 1515 (Oregon Laws 2016, chapter 106.) A proctor foster home means a foster home certified by a child-caring agency. Most of these rule changes have been in place as temporary rules that took effect July 1, 2016.

These rule changes —

- Set out the standards child-caring agencies must comply with as provided in section 4 of SB 1515;

- Update definitions to align with SB 1515, including "child in care," "child-caring agency," and "proctor foster home" and consolidating definitions in an overarching definitions rule;

- Require compliance with all applicable laws and rules, and the internal policies and procedures of the child-caring agency as a condition of licensure;

- Establish new financial oversight requirements required in SB 1515;

- Add specific rights for children and families served by child-caring agencies, including a prohibition on the restriction of child-parent communication as a condition of program participation, and a requirement that child-caring agencies must afford the rights under ORS 418.200 - 418.202 to children in the care or custody of the Department;

- Require child-caring agencies to have child abuse reporting policies, procedures, and training as required in section 37 of SB 1515;

- Clarify requirements related to the internal written policies and procedures child-caring agencies must have, including the additional requirement to have a suicide prevention policy and requiring policies to be submitted at initial application and renewal;

- Require 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;

- Require child-caring agencies to provide access to children in care and the agencies' premises as required in section 20 of SB 1515 and, for those child-caring agencies who care for children on a 24-hour basis, to obtain parental consent to allow access to the child as required in SB 1515 and the licensing rules;

- Require 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;

- State that the Department will investigate when it becomes aware that abuses, deficiencies, or failures to comply may be occurring in a child-caring agency;

- Update the civil penalty criteria consistent with section 31 of SB 1515;

- Require annual inspections of premises where children reside or receive services;

- Grant new authority for the Department to take licensing enforcement actions when licensing violations exist;

- Require licensing enforcement actions in certain circumstances;

- Update the foster care agency rules to align with the rules for Department-certified foster homes;

- Require prospective adoptive parents to sign a release of information regarding previous adoption application denials;

- Update requirements for therapeutic boarding schools;

- Update rules in OAR chapter 413, division 10 relating to client rights to reflect new terminology and align notice and hearing rights with SB 1515, DOJ rules in OAR chapter 137, and ORS chapter 183; and

- Make additional housekeeping changes to align requirements for different types of child-caring agencies; improve the organization of the rules; and update terminology to align with SB 1515.

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 law and Department practices; update statutory and rule references; correct formatting and punctuation; improve ease of reading; and clarify Department rules and processes.

The Department is amending additional rules to implement SB 1515, including rules for the Office of Child Welfare Programs (including Child Protective Services, Behavior Rehabilitation Services, and Monthly Contact and Monitoring Child and Young Adult Safety), the Office of Adult Abuse Prevention and Investigations, and the Background Check Unit. Those rule changes can be viewed at http://www.dhs.state.or.us/policy/childwelfare/drafts/drafts.htm. More information about the implementation of SB 1515 is available at https://www.oregon.gov/DHS/CHILDREN/Pages/sb1515.aspx.

Rules Coordinator: Kris Skaro—(503) 945-6067

413-010-0000
Definitions

The following definitions apply to OAR chapter 413, division 10.

(1) "Adoption assistance" means assistance provided on behalf of an eligible child or young adult to offset the costs associated with adopting and meeting the ongoing 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.

(2) "Adoption records, papers, and files" means all documents, writings, information, exhibits, and other filings retained in the court's record of an adoption case pursuant to ORS 109.319 and includes but is not limited to the Adoption Summary and Segregated Information Statement described in ORS 109.317 and exhibits attached to the statement, the petition and exhibits attached to the petition pursuant to ORS 109.315, and any other motion, judgment, document, writing, information, exhibit, or filing retained in the court's record of the adoption case.

(3) "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.

(4) "Adult" means a person 18 years of age or older.

(5) "Base rate payment" means a payment to the foster parent or relative caregiver at a rate established by the Department 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.

(6) "Case plan" means a written, goal oriented, and time-limited individualized plan for the child and the child's family, developed by the Department and the parents or guardians, to achieve the child's safety, permanency, and well-being.

(7) "Central Office CPS Founded Disposition Review" means a process wherein a Central Office CPS Founded Disposition Review Committee reviews a founded disposition, makes recommendations to the CPS Program Manager or designee, and the CPS Program Manager or designee makes a decision to uphold, overturn, or change the abuse type of the founded disposition.

(8) "Central Office CPS Founded Disposition Review Committee" means a group of two child welfare employees who make a recommendation or recommendations to the Child Protective Services Program Manager or designee regarding the CPS founded disposition. No one may serve on the "Central Office CPS Founded Disposition Review Committee" who participated in or observed the Local Child Welfare Office CPS Founded Disposition Review or had a role in the CPS assessment, including having participated in a staffing, that resulted in the CPS founded disposition under review. Further requirements of the "Central Office CPS Founded Disposition Review Committee" are found in OAR 413-010-0745 and 413-010-0746. The two child welfare staff on the committee must include any two of the following:

(a) Either the Program Manager for CPS or a designee;

(b) A CPS program coordinator;

(c) A CPS consultant; or

(d) A Department supervisor.

(9) "Certificate of Approval" means a document that the Department issues to approve the operation of a child-specific relative caregiver home, child-specific foster home, pre-adoptive home, or a regular foster home.

(10) "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.

(11) "Child" means a person under 18 years of age.

(12) "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.

(13) "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.

(14) "Client" means any individual receiving services from the Department, including the parent or legal guardian of a child or young adult, or the custodian of an unemancipated minor client.

(15) "Client file" means an electronic or paper file that the Department marks with the names of one or more clients, into which the Department places all of the named clients' records. A "client file" may contain confidential information about other clients and persons who are not clients.

(16) "Client information" means confidential information about a client or identified with a client.

(17) "Client record" means any record that includes client information and is created, requested, or held by the Department. A "client record" does not include general information, policy statements, statistical reports, or similar compilations of data which are not identified with an individual child, family or other recipient of services.

(18) "Confidential information" means information that is unavailable to the public by statute, rule, or court order.

(19) "Contract Provider" means any individual or organization that provides services to a Child Welfare client pursuant to a contract or agreement with Child Welfare.

(20) "Court Appointed Special Advocate (CASA)" means a volunteer who is appointed by the court, is a party to the juvenile proceeding, and advocates for the child pursuant to ORS 419A.170.

(21) "CPS Disposition" means a determination that completes a CPS assessment. Dispositions are discussed in OAR 413-015-1000 and include founded, unfounded, and unable to determine.

(22) "Department" means the Department of Human Services, Child Welfare.

(23) "Department adoption records" means all documents, writings, and information required to be retained in the Department's Central Office adoption file including, but not limited to:

(a) Adoption records, papers, and files;

(b) Records and information created, generated, produced, or submitted for purposes of selecting the adoptive family for the child;

(c) Documents, writings and information obtained, created, or submitted by the Department Child Permanency Program staff for the purposes of finalizing the child's adoption;

(d) Records and information obtained or created by the Department for the purposes of determining eligibility or making payment for adoption assistance;

(e) Any medical, psychiatric, or psychological records of the child received by the Child Permanency Program staff for retention as part of the Child Permanency Program adoption file of the child;

(f) The names, address, or other identifying information of the adoptive family of the child; and

(g) The birth certificate of the child.

(24) "Discipline" means a training process a family uses to help a child or young adult 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.

(25) "Disclose" means reveal or provide client information to a person, agency, organization, or other entity outside of the Department of Human Services. Disclosing includes, but is not limited to:

(a) Showing or providing a client record or copy of a client record; and

(b) Orally transmitting client information.

(26) "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.

(27) "Guardian" means an individual who has been granted guardianship of a child through a judgment of the court.

(28) "Guardianship assistance" means assistance provided by the Department to the guardian on behalf of an eligible child or young adult to offset costs associated with meeting the ongoing needs of the child or young adult. "Guardianship assistance" may be in the form of a payment, medical coverage, or reimbursement of guardianship expenses.

(29) "Indian child" means an unmarried person who is under 18 years of age and who is either a member of an Indian tribe or is eligible for membership in an Indian tribe and who is the biological child of a member of an Indian tribe.

(30) "Juvenile" means a person younger than the age of 18 years who is identified as a perpetrator. OAR 413-010-0716 provides specific requirements regarding application of these rules to juveniles.

(31) "Legal finding" means a court or administrative finding, judgment, order, stipulation, plea, or verdict that determines who was responsible for the child abuse that is the subject of a CPS founded disposition.

(32) "Legal proceeding" means a court or administrative proceeding that may result in a legal finding.

(33) "Legally emancipated " means a person under 18 years of age who is married or has been emancipated by the court in accordance with the requirements of ORS 419B.558.

(34) "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 as determined by applying the CANS algorithm to the results of the CANS screening.

(35) "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.

(36) "Licensee" means a child-caring agency that holds a license issued by the Department.

(37) "Local Child Welfare Office CPS Founded Disposition Review" means a process wherein a Local Child Welfare Office CPS Founded Disposition Review Committee reviews a founded disposition, makes recommendations to a Child Welfare program manager or designee, and the Child Welfare program manager or designee makes a decision to uphold, overturn, or change the abuse type of the founded disposition.

(38) "Local Child Welfare Office CPS Founded Disposition Review Committee" means a group of two child welfare employees who make a recommendation or recommendations to a Child Welfare Program Manager or designee regarding a CPS founded disposition. One of the members must be a manager and one must be staff trained in CPS assessment and dispositions. No one may serve on the "Local Child Welfare Office CPS Founded Disposition Review Committee" in the review of an assessment in which he or she had a role in the CPS assessment, including having participated in a staffing, that resulted in the CPS founded disposition under review. Further requirements of the "Local Child Welfare Office CPS Founded Disposition Review Committee" are found in OAR 413-010-0735 and 413-010-0738.

(39) "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, 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.

(40) "Participating tribe" means a federally recognized Indian tribe in Oregon with a Title IV E agreement with the Department.

(41) "Party" means a person entitled to a contested case hearing under these rules.

(42) "Perpetrator" means the person the Department has reasonable cause to believe is responsible for child abuse in a CPS founded disposition.

(43) "Person Requesting Review" or "Requestor" means a perpetrator, his or her attorney, or, if a juvenile is identified as the perpetrator, the

person who may request a review on behalf of the juvenile, who requests a review of the founded disposition.

(44) "Potential guardian" means an individual who:

(a) Has been approved by the Department or participating tribe to be a child's guardian; and

(b) Is in the process of legalizing the relationship to the child through the judgment of the court.

(45) "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.

(46) "Record" means a record, file, paper, or communication and includes, but is not limited to, any writing or recording of information including automated records and printouts, handwriting, typewriting, printing, photostating, photographing, magnetic tapes, videotapes, or other documents. "Record" includes records that are in electronic form.

(47) "Registered domestic partner" means an individual joined in a domestic partnership that has been registered by a county clerk in accordance with ORS 106.300 to 106.340.

(48) "Relative" means any of the following:

(a) An individual with one of the following relationships to the child or young adult through the parent of the child or young adult unless the relationship has been dissolved by adoption of the child, young adult, or parent:

(A) Any blood relative of preceding generations denoted by the prefixes of grand, great, or great-great.

(B) Any half-blood relative of preceding generations denoted by the prefixes of grand, great, or great-great. Individuals with one common biological parent are half-blood relatives.

(C) An aunt, uncle, nephew, niece, first cousin, and first cousin once removed.

(D) A spouse of anyone listed in paragraphs (A) to (C) of this subsection, even if a petition for annulment, dissolution, or separation has been filed or the marriage is terminated by divorce or death. To be considered a "relative" under this paragraph, the child or young adult must have had a relationship with the spouse prior to the most recent episode of Department custody.

(b) An individual with one of the following relationships to the child or young adult:

(A) A sibling, also to include an individual with a sibling relationship to the child or young adult through a putative father.

(B) An individual defined as a relative by the law or custom of the tribe of the child or young adult if the child or young adult is an Indian child under the Indian Child Welfare Act or in the legal custody of a tribe.

(C) An individual defined as a relative of a refugee child or young adult under OAR 413-070-0300 to 413-070-0380.

(D) A stepparent or former stepparent if the child or young adult had a relationship with the former stepparent prior to the most recent episode of Department custody; a stepbrother; or a stepsister.

(E) A registered domestic partner of the parent of the child or young adult or a former registered domestic partner of the parent of the child or young adult if the child or young adult had a relationship with the former domestic partner prior to the most recent episode of Department custody.

(F) The adoptive parent or an individual who has been designated as the adoptive resource of a sibling of the child or young adult.

(G) An unrelated legal or biological father or mother of a half-sibling of the child or young adult when the half-sibling of the child or young adult is living with the unrelated legal or biological father or mother.

(c) An individual identified by the child or young adult or the family of the child or young adult, or an individual who self-identifies, as being related to the child or young adult through the parent of the child or young adult by blood, adoption, or marriage to a degree other than an individual specified as a "relative" in paragraphs (A) to (C) of subsection (a) of this section unless the relationship has been dissolved by adoption of the child, young adult, or parent.

(d) An individual meeting the requirements of at least one of the following:

(A) An individual not related to the child, young adult, or parent by blood, adoption, or marriage:

(i) Who is identified as a member of the family by the child or young adult or by the family of the child or young adult; and

(ii) Who had an emotionally significant relationship with the child or young adult or the family of the child or young adult prior to the most recent episode of Department custody.

(B) An individual who has a blood relationship to the child or young adult as described in paragraphs (A) to (C) of subsection (a) of this section through the birth parent of the child or young adult, but the prior legal relationship has been dissolved by adoption of the child, young adult, or birth parent, and who is identified as a member of the family by the child or young adult or who self-identifies as a member of the family.

(e) For eligibility for the guardianship assistance program:

(A) A stepparent is considered a parent and is not a "relative" for the purpose of eligibility for guardianship assistance unless a petition for annulment, dissolution, or separation has been filed, or the marriage to the adoptive or biological parent of the child has been terminated by divorce or death.

(B) A foster parent may only be considered a "relative" for the purpose of eligibility for guardianship assistance when:

(i) There is a compelling reason why adoption is not an achievable permanency plan;

(ii) The foster parent is currently caring for a child, in the care or custody of the Department or a participating tribe, who has a permanency plan or concurrent permanent plan of guardianship;

(iii) The foster parent has cared for the child for at least 12 of the past 24 months; and

(iv) The Department or tribe has approved the foster parent for consideration as a guardian.

(49) "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.

(50) "Request for a Central Office CPS Founded Disposition Review" means a written request for a Central Office CPS Founded Disposition Review from a requestor who has received a Local Child Welfare Office CPS Founded Disposition Review Decision (Form CF 314) to retain a founded disposition. The specific requirements for a request for review by Central Office are described in OAR 413-010-0740.

(51) "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.

(52) "Service" means assistance that the Department provides clients.

(53) "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.

(54) "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.

(55) "Substitute caregiver" means a relative caregiver, foster parent, or provider authorized to provide care to a child or young adult in the legal or physical custody of the Department.

(56) "Voluntary services" means services that the Department provides at the request of a person or persons and there is no open and related juvenile court proceeding.

(57) "Young adult" means a person 18 through 20 years of age.

Stat Auth.: ORS 409.050, 418.005

Stats. Implemented: ORS 409.010, 409.225, 419A.255

Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 9-1999, f. 5-24-99, cert. ef. 6-1-99; CWP 18-2011, f. & cert. ef. 9-2-11; CWP 12-2013, f. 12-31-13, cert. ef. 1-1-14; CWP 13-2015, f. & cert. ef. 8-4-15; CWP 22-2015, f. & cert. ef. 10-6-15; CWP 2-2016, f. & cert. ef. 2-1-16; CWP 22-2016, f. & cert. ef. 12-1-16

413-010-0500

Purpose, Right to Request Hearing, Applicable Rules, and Computation of Time

(1) The purpose of these rules (OAR 413-010-0500 to 413-010-0535) is to:

(a) State the rights of individuals and entities to request a contested case hearing when the Department takes certain actions; and

(b) Set forth rules governing some aspects of the contested case hearings process.

(2) The individuals and entities described below have the right to request a contested case hearing under ORS Chapter 183. In order to exercise the right to a hearing, the individual or entity must submit and the Department must receive a hearing request which complies with OAR 413-010-0505 within the timeframes described in that rule.

(a) A child or young adult placed in substitute care by the Department may request a hearing in the manner set forth in OAR 413-010-0505 when

the Department issues a notice and decision that includes a statement of hearing rights that:

(A) Reduces or terminates the base rate payment;

(B) Determines, denies, reduces or terminates a level of care payment;

(C) Determines, denies, reduces or terminates a level of personal care payment;

(D) Denies eligibility under Title IV-E of the Social Security Act when such denial impacts a benefit;

(E) Denies, reduces or terminates the base rate payment made on behalf of the child's or young adult's minor child when the minor child:

(i) Lives with the child or young adult in substitute care; and

(ii) Is not in the legal custody of the Department; or

(F) Denies eligibility for medical assistance under Child Welfare Policy I-E.6.2, "Title XIX and General Assistance Medical Eligibility," (OAR 413-100-0400 through 413-100-0610) when such denial impacts assistance.

(G) Denies prior authorization for the BRS Program under Child Welfare Policy I-E.5.1.1.1, "Behavior Rehabilitation Services Program," (OAR 413-090-0075(2)(b)).

(b) Unless an adoption assistance agreement automatically expires, a pre-adoptive family or an adoptive family applying for or receiving adoption assistance under Child Welfare Policy I-G.3.1, "Adoption Assistance," (OAR 413-130-0000 to 413-130-0130) may request a hearing in the manner set forth in OAR 413-010-0505 when the Department issues a notice and decision that includes a statement of hearing rights and:

(A) Denies Title IV-E adoption assistance benefits;

(B) Denies adoption assistance from state funds;

(C) Reduces adoption assistance payments or terminates adoption assistance without the concurrence of the adoptive family;

(D) Reduces adoption assistance payments or terminates adoption assistance for a reason other than a child turning age 18 or a young adult turning age 21 when an extension has been granted; or

(E) Offers the family a specific amount or type of adoption assistance when the Department and the adoptive family or pre-adoptive family are unable to reach agreement through a negotiation or renegotiation under OAR 413-130-0070 or 413-130-0075.

(c) Unless a guardianship assistance agreement automatically expires, a potential guardian or a guardian applying for or receiving guardianship assistance payments under Child Welfare Policy I-E.3.6.2, "Guardianship Assistance," (OAR 413-070-0900 to 413-070-0974) in the manner set forth in OAR 413-010-0505 when the Department issues a notice and decision that includes a statement of hearing rights and:

(A) Denies Title IV-E guardianship assistance benefits;

(B) Terminates, reduces, or otherwise changes guardianship assistance payments without the concurrence of the guardian;

(C) Terminates guardianship assistance for a reason other than a child turning age 18 or a young adult turning age 21 when an extension has been granted; or

(D) Offers the family a specific amount or type of guardianship assistance when the Department and the guardian or potential guardian are unable to reach agreement through a negotiation or renegotiation under OAR 413-070-0917, 413-070-0939, or 413-070-0969.

(d) An applicant for a Certificate of Approval or a certified family may request a hearing in the manner set forth in OAR 413-010-0505 when the Department denies the application or revokes a certificate under Child Welfare Policy II-B.1, "Standards for Certification of Foster Parents, Relative Caregivers, and Approval of Potential Adoptive Resources," (OAR 413-200-0301 to 413-200-0396).

(e) An applicant for a license to operate a child-caring agency or a licensee may request a hearing in the manner set forth in OAR 413-215-0121 when the Department denies, suspends, revokes, or places conditions on a license or imposes a civil penalty.

(f) An applicant to adopt or an applicant for a Certificate of Approval may request a hearing in the manner set forth in OAR 413-010-0500 when the Department determines that the applicant is unfit based on the criminal offender information or a false statement regarding criminal offender information of the applicant or of another individual in the household of the applicant under Child Welfare Policy I-G.1.4, "Criminal Records Check Requirements for Relative Caregivers, Foster Parents, Adoptive Resources, and Other Persons in the Household," (OAR 413-120-0400 to OAR 413-120-0475).

(3) A person may request a hearing in the manner set forth in OAR 413-010-0505 when that person has the right to a contested case hearing under a statute concerning Child Welfare Programs or a rule in Chapter 413.

(4) These rules (OAR 413-010-0500 to 413-010-0535), apply to contested cases arising from the properly made hearings requests described in sections (2) and (3) of this rule. The following other rules do or do not apply as noted:

(a) OAR 137-003-0501 to 137-003-0700 apply to these contested cases, except to the extent that rules in Chapter 413 are permitted to and provide otherwise.

(b) Rules in Chapter 461 do not apply to these contested cases unless a rule in Chapter 413 expressly refers to them.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 183.411 - 183.685, 411.095 & 418.005

Hist.: SOSCF 32-2001, f. 6-29-01 cert. ef. 7-1-01; CWP 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; CWP 10-2009(Temp), f. & cert. ef. 9-1-09 thru 12-28-09; CWP 20-2009, f. & cert. ef. 12-29-09; CWP 8-2011(Temp), f. & cert. ef. 6-30-11 thru 12-27-11; CWP 27-2011, f. 11-3-11, cert. ef. 11-4-11; CWP 6-2012, f. & cert. ef. 9-7-12; CWP 10-2013, f. 11-14-13, cert. ef. 1-1-14; CWP 22-2016, f. & cert. ef. 12-1-16

413-010-0502
Representation

(1) When a child or young adult has the right to a hearing because the Department takes an action under OAR 413-010-0500(2)(a), the foster parent or relative caregiver may:

(a) Request a hearing on behalf of the child or young adult; and

(b) Participate in the hearing as a representative on behalf of the child or young adult.

(2) When the Department takes an action to deny, reduce, or terminate a benefit or service that is provided under Title IV-E or Title XIX of the Social Security Act, a party that is not an entity may be represented by an attorney, a relative, a friend, or other spokesperson as authorized by federal law.

(3) In all other cases, a party may represent themselves or be represented by an attorney.

(4) The Department, with the consent of the Attorney General, has authorized its employees to represent the Department in cases involving the actions described in OAR 413-010-0500(2)(a).

(5) A Department employee acting as the Department's representative may not make legal argument on behalf of the Department.

(a) "Legal argument" includes argument on:

(A) The jurisdiction of the Department to hear the contested case;

(B) The constitutionality of a statute or administrative rule or the application of a constitutional requirement to the Department; and

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal argument" does not include presentation of a motion, evidence, examination and cross-examination of a witness, or presentation of a factual argument or arguments on:

(A) The application of a statute or administrative rule to the facts in the contested case;

(B) Comparison of a prior Department action when handling a similar situation;

(C) The literal meaning of a statute or administrative rule directly applicable to an issue in the contested case;

(D) The admissibility of evidence; and

(E) The correctness of a procedure being followed in the contested case hearing.

(6) The Department may be represented in any contested case proceeding by the Department of Justice.

(7) Contested cases under these rules are not open to the public and are closed to nonparticipants, except nonparticipants may attend subject to the consent of each party and the Department.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 183.411 - 183.685, 411.095, 418.005

Hist.: CWP 8-2011(Temp), f. & cert. ef. 6-30-11 thru 12-27-11; CWP 27-2011, f. 11-3-11, cert. ef. 11-4-11; CWP 22-2016, f. & cert. ef. 12-1-16

413-010-0505
Hearing Requests

(1) To request a hearing under OAR 413-010-0500(2)(a):

(a) The party or the party's representative must complete and sign a hearing request form approved by the Department: and

(b) The form must be received by the Department not later than 30 days following the mailing date or date of personal delivery of the notice.

(2) Requests for a hearing under OAR 413-010-0500(2)(b)-(d) and (f)-(g) must be in writing and must be postmarked or received by the Department by the date specified in the Department's notice or the applicable rule setting a hearing request deadline, whichever is later.

(3) In the event a request for a hearing is not timely, OAR 137-003-0528 applies, except to the extent provided otherwise in section (5) of this rule.

(4) If a contested case notice was sent by regular mail, and the party or party's representative indicates that neither the party nor the party's representative received or had actual knowledge of the contested case notice, the Department must advise the party or party's representative of the right to request a hearing under section (5) of this rule.

(5) When the Department receives a hearing request that is not filed within the timeframe required by section (1) or section (2) of this rule but is filed no later than 60 days after a notice becomes a final order under OAR 413-010-0510(3):

(a) If the Department finds that the party and party's representative did not receive the written notice and did not have actual knowledge of the notice, the Department refers the request for a hearing to the Office of Administrative Hearings (OAH) for a contested case hearing on the merits of the Department's action described in the notice.

(b) The Department may refer the request for a hearing to the OAH for a contested case proceeding to determine whether the party or party's representative received the written notice or had actual knowledge of the notice. At the hearing, the Department must show that the party or party's representative had actual knowledge of the notice or that the Department mailed the notice to the correct address of the party or party's representative.

(6) Upon receipt of a hearing request that is not described in OAR 413-010-0500(2), the Department may enter an order that the hearing request is not eligible for referral to OAH. Alternately, the Department may refer a hearing request to OAH for a decision on the question of whether there is a right to a contested case hearing.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 183.411 - 183.685, 411.095, 411.103 & 418.005
Hist.: 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 20-2009, f. & cert. ef. 12-29-09; CWP 8-2011(Temp), f. & cert. ef. 6-30-11 thru 12-27-11; CWP 27-2011, f. 11-3-11, cert. ef. 11-4-11; CWP 22-2016, f. & cert. ef. 12-1-16

413-010-0510
Notice

(1) When the Department takes any of the actions described in OAR 413-010-0500(2), the Department issues a written notice to the person that has the right to a contested case hearing.

(2) When the Department takes any of the actions described in OAR 413-010-0500(2)(a)-(c), the written notice must:

(a) Specify the date the notice is mailed or personally delivered;

(b) Specify the action the Department intends to take and the effective date of the action. If benefits are reduced or closed to reflect cost-of-living adjustments in benefits or other mass change under a program operated by a federal agency or to reflect a mass change to payments in another program operated by the Department, it is sufficient to meet this requirement that the notice state all of the following:

(A) The general nature of the change.

(B) Examples of how the change affects the benefits of the group of affected clients.

(C) The month in which the change will take place.

(c) Specify the circumstances under which payments or benefits are continued if a hearing is requested and whether continued payments or benefits may be subject to recovery by the Department if the Department's action is upheld; and

(d) If the Department intends to terminate benefits or payments because the individual is ineligible for the benefits or payments or the program is terminated, state that the individual may reapply for assistance if circumstances affecting the eligibility of the individual change.

(3) Department notices indicate that the Department designates the record of the proceeding, including information in the Department's file or files and materials added by a party, as the record upon default. When the Department issues a notice to which OAR 137-003-0672 applies, unless another rule in OAR chapter 413 provides otherwise, the Department's notice becomes a final order:

(a) The day after the date prescribed in the notice as the deadline for requesting the hearing if the party fails to request a hearing; or

(b) The day the Department or OAH mails an order dismissing the hearing request because the party withdraws the request or fails to appear on the date and at the time set for the hearing.

(4) When the Department terminates or reduces benefits or services under subsections (2)(a) through (2)(c) of OAR 413-010-0500, the Department must send the notice:

(a) At least 10 calendar days before the effective date of the action, except as provided in subsection (b) of this section.

(b) When the Department changes a benefit standard that results in the reduction, suspension or closure of a grant of public assistance:

(A) At least 30 days before the effective date of the action; or

(B) At least 10 working days before the effective date of the action when the Department has fewer than 60 days before the effective date to implement the proposed change.

(c) For purposes of this rule, the term "changes a benefit standard" means a change to the applicable inflation-adjusted contribution, income, or payment standard. It does not include the annual adjustment to a standard based on a federal or state inflation rate.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 183.411 - 183.685, 411.095, 418.005
Hist.: CWP 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; CWP 20-2009, f. & cert. ef. 12-29-09; CWP 8-2011(Temp), f. & cert. ef. 6-30-11 thru 12-27-11; CWP 27-2011, f. 11-3-11, cert. ef. 11-4-11; CWP 22-2016, f. & cert. ef. 12-1-16

413-010-0525
Burden of Proof

In any contested case covered by these rules (OAR 413-010-0500 to 413-010-0535):

(1) The Department has the burden of proof for the revocation of a certificate of approval, the suspension or revocation of a license, or the imposition of a civil penalty.

(2) In cases not covered by section (1) of this rule, the party has the burden of proof.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 183.411 - 183.685, 411.095, 418.005
Hist.: CWP 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; CWP 20-2009, f. & cert. ef. 12-29-09; CWP 8-2011(Temp), f. & cert. ef. 6-30-11 thru 12-27-11; CWP 27-2011, f. 11-3-11, cert. ef. 11-4-11; CWP 22-2016, f. & cert. ef. 12-1-16

413-010-0535
Proposed and Final Orders

(1) When the Department refers a contested case under these rules (OAR 413-010-0500 to 413-010-0535) to OAH, the Department indicates on the referral whether the Department is authorizing:

(a) A proposed order;

(b) A proposed and final order (OAR 137-003-0645(4); or

(c) A final order.

(2) During or after a contested case hearing, when it is determined that the correct application of OAR 413-020-0230, 413-090-0133, or 413-090-0150 requires the consideration of facts that differ from the facts on which the Department made a decision to deny, reduce, or terminate either a level of care payment or a level of personal care payment, the Department will reapply OAR 413-020-0230, 413-090-0133, or 413-090-0150 based on new or different facts.

(3) When the Department authorizes either a proposed order or a proposed and final order:

(a) The party may file written exceptions and written argument to be considered by the Department. The exceptions and argument must be received at the location indicated in the order, and postmarked or received not later than the tenth day after service of the proposed order or proposed and final order.

(b) If the party does not submit timely exceptions or argument following a proposed and final order, the proposed and final order becomes a final order on the eleventh day after service of the proposed and final order unless the Department has issued a revised order or has notified the parties and the administrative law judge that the Department will issue the final order.

(c) When the Department receives timely exceptions or argument, the Department issues the final order, unless the Department requests that OAH issue the final order under OAR 137-003-0655.

(4) A request by a party for reconsideration or rehearing must be filed with the person who signed the final order within the time limits of OAR 137-003-0675.

(5) A final order should be issued or the case otherwise resolved no later than 90 days following the receipt of the request for a hearing.

(6) A final order is effective immediately upon being signed or as otherwise provided in the order.

(7) The Department reserves the right to withdraw or amend any final order issued by OAH or the Department at any time permitted by law.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 183.411 - 183.685, 411.095, 418.005
Hist.: CWP 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; CWP 20-2009, f. & cert. ef. 12-29-09; CWP 8-2011(Temp), f. & cert. ef. 6-30-11 thru 12-27-11; CWP 27-2011, f. 11-3-11, cert. ef. 11-4-11; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0000
Definitions for OAR Chapter 413, Division 215

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 an individual who meets the clinical supervisor qualifications in OAR 309-022-0125.

(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, and equipment 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 10 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 children in care 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 OAR chapter 413, division 215.

(37) "Qualified Mental Health Professional (QMHP)" means an individual who meets the QMHP qualifications in OAR 309-022-0125.

(38) "Re-adoption" means a process in which a child whose adoption was completed in another country is re-adopted in this country.

(39) "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 to participate in extracurricular, enrichment, cultural, and social activities.

(40) "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.

(41) "Residential care agency" means a child-caring agency that provides services to children 24 hours a day.

(42) "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.

(43) "Shelter" means a facility operated by a child-caring agency that provides services for a limited duration to homeless or runaway youth.

(44) "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.

(45) "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.

(46) "Staff" means employees of the child-caring agency who are responsible for providing care, services, or treatment to a child in care.

(47) "Stationary outdoor youth program" means an outdoor youth program which remains in a stationary location that houses children in care.

(48) "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.

(49) "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.

(50) "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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0001
Licensing Umbrella Rules: Regulation of Child-caring Agencies

(1) The Department is required to regulate and license certain organizations and agencies that care for children. The rules in OAR chapter 413, division 215 establish the requirements of the Department for obtaining and maintaining the required license, and the policies of the Department required by ORS 418.205 to 418.327.

(2) These umbrella rules (OAR 413-215-0001 to 413-215-0131) apply to all of the following types of child-caring agencies:

(a) An adoption agency (further regulated by OAR 413-215-0401 to 413-215-0481).

(b) A child-caring agency (further regulated by OAR 413-215-0301 to 413-215-0396) that offers to place children for foster care by taking physical custody of and then placing the children in proctor foster homes approved by the child-caring agency.

(c) A child-caring agency (further regulated by OAR 413-215-0501 to 413-215-0586) that provides residential care services to children 24 hours a day.

(d) A child-caring agency that provides an outdoor youth program (further regulated by 413-215-0901 to 413-215-1031).

(e) A child-caring agency (further regulated by OAR 413-215-0801 to 413-215-0876) that provides day treatment for children in care with emotional disturbances.

(f) A child-caring agency (further regulated by OAR 413-215-0701 to 413-215-0766) that provides residential services or operates a shelter, mass shelter, or transitional living program for homeless or runaway youth, pregnant or parenting girls, or other children in care working towards independent living.

(g) An academic boarding school (further regulated by OAR 413-215-0201 to 413-215-0276).

(h) A therapeutic boarding school (further regulated by OAR 413-215-0601 to 413-215-0681).

(i) A child-caring agency providing other services for children similar to the services covered by subsections (a) to (h) of this section or other child-caring agency that falls under ORS 418.205(2)(a).

(3) A child-caring agency must comply with all of the Department rules that apply to the child-caring agency.

(4) A child-caring agency engaged in providing residential care for both adults and children is subject to the rules in OAR chapter 413, division 215, unless each child in care residing in the child-caring agency's facility has a custodial parent residing in the facility.

(5) All child-caring agencies, their governing boards, and executive director, and program director, employees, contractors, and agents shall ensure the following standards, procedures, and protocols are met:

(a) The child-caring agency ensures child and family rights.

(b) The child-caring agency complies with abuse reporting and investigation requirements including, but not limited to, having and following abuse reporting procedures as required in OAR 413-215-0056 and providing training as required in OAR 413-215-0061.

(c) The child-caring agency engages in and applies appropriate behavior management techniques.

(d) The child-caring agency provides adequate furnishings and personal items for children.

(e) The child-caring agency provides appropriate food services.

(f) The child-caring agency ensures the safety of children, including ensuring adequate supervision.

(g) The agency utilizes approved procedures and protocols for use of medications for children receiving care or services from the child-caring agency.

(h) The child-caring agency or the child-caring agency's employees or agents have not engaged in financial mismanagement.

(i) The child-caring agency fully and timely corrects violations and maintains standards in accordance with any plan of correction imposed by the Department.

(j) The child-caring agency provides access to a child in care or the child-caring agency's premises to the Department or the Department's employees, investigators, court appointed special advocates, attorneys for a child in care, 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, or other authorized persons or entities as required under ORS 418.305 and OAR 413-215-0091 and 413-215-0101.

(k) The child-caring agency permits the Department to inspect agency records including, but not limited to, financial records, treatment records, services delivery records, logs, incident reports, case notes, medication records, and medical treatment records.

(l) The child-caring agency is incorporated as required by ORS 418.215 and OAR 413-215-0016.

(m) The child-caring agency is in full compliance with the standards of care and treatment in these rules.

(6) Department staff responsible for the regulation and oversight of child-caring agencies must review licensing applications, conduct on-site inspections, investigate complaints, and carry out all other duties necessary to ensure the safe operation of child-caring agencies. The Department will measure the time and resources needed to carry out these duties to create a workload model. The workload model will guide the Department when

seeking additional resources to meet the Department's regulatory oversight responsibilities under Oregon law.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0011
Licensing Umbrella Rules: 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 OAR chapter 413, division 215. A licensee must at all times comply with the provisions of the license and with all laws and 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 OAR chapter 413, division 215, except the services the child-caring agency is authorized by law and 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0016
Licensing Umbrella Rules: 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 OAR chapter 413, division 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0021
Licensing Umbrella Rules: 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 child-caring 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 or audit 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.

(g) Approval from the Department's Background Check Unit as required in OAR 407-007-0200 to 407-007-0370.

(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 OAR chapter 413, division 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 these activities.

(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 10 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 abili-

ty or fitness to carry out the duties imposed by these rules and governing statutes.

(d) Any instance the child-caring agency becomes aware of 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0026
Licensing Umbrella Rules: 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

(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

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0031
Licensing Umbrella Rules: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0036
Licensing Umbrella Rules: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0041
Licensing Umbrella Rules: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0046
Licensing Umbrella Rules: 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 consistent with any court orders governing contact with a parent or legal guardian. This right cannot be waived, including voluntarily. Restriction on communication between a child in care and his or her parent or legal guardian may not be a condition of participation in the program.

(b) The child in care's right to privacy.

(c) The child in care's right to participate in service planning or educational program planning.

(d) The child in care's right to fair and equitable treatment.

(e) The child in care's right to file a grievance (as provided in section (2) of this rule) 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. For an academic boarding school, this subsection only applies to grievances about health or safety issues. 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 the care or custody of the Department 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0051
Licensing Umbrella Rules: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0056
Licensing Umbrella Rules: 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, 419B.015, and Oregon Laws 2016, chapter 106 that includes requirements that child-caring 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0061
Licensing Umbrella Rules: 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 check 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 definitions of abuse that apply 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 OAR chapter 413, division 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.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0066
Licensing Umbrella Rules: Privacy

(1) A child-caring agency must have and adhere to 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0071
Licensing Umbrella Rules: 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 OAR chapter 413, division 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 OAR chapter 413, division 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 regarding current or prior children in care.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0076
Licensing Umbrella Rules: Discipline, Behavior Management, and Suicide Prevention (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 adopt and adhere to written policies and procedures on discipline, behavior management, and suicide prevention that meet all of the requirements of this rule. Copies of the policies must be provided to the Department as provided in OAR 413-215-0081 and any time policies are adopted or amended.

(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)(d)(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 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.

(b) 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.

(c) 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 record.

(d) 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 or proctor foster parent 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.

(e) 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 15 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.

(f) 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.

(4) Suicide Prevention. The policy must include the following:

(a) How the child-caring agency will respond in the event a child in care exhibits self-injurious, self-harm, or suicidal behavior;

(b) Warning signs of suicide;

(c) Emergency protocol and contacts;

(d) Training requirements for staff, including suicide prevention training and suicide risk assessment tool training;

(e) Procedures for determining implementation of additional supervision precautions and for determining removal of additional supervision precautions;

(f) Suicide risk assessment procedures on the day of intake;

(g) Documentation requirements for suicide ideation, self-harm, and special observation precautions to ensure immediate communication to all staff;

(h) A process for tracking suicide behavioral patterns; and

(i) A "post-intervention" plan with identified resources.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0081

Licensing Umbrella Rules: Application for License, Renewal, or to Add a Program

(1) For purposes of this rule, "applicant" means a child-caring agency that is in the process of applying to the Department for an initial license or license renewal or to add a program to an existing license.

(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.

(C) To add a program to an existing license.

(b) An applicant must apply for a license on forms provided by the Department.

(c) A licensee must submit an application for renewal prior to the expiration of the current license. 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.

(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 completed "CCA Contact Information" form that includes the current board of directors, including names, term, and office held and contact information for the board of directors, management personnel, other regulatory authorities, and state or governmental agencies or units with whom the child-caring agency contracts to provide care or services to children.

(d) A complete personnel list with job titles.

(e) An organization chart with job titles and staff names.

(f) Documentation that a background check was completed as required in OAR 407-007-0200 to 407-007-0370 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 and training 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) Written policies on discipline, behavior management, and suicide prevention that meet 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 10 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) 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) Current "CCA Contact Information" form as described in subsection (3)(d) of this rule.

(c) A complete personnel list with job titles.

(d) An organization chart with job titles and staff names.

(e) Documentation that a background check was completed as required in OAR 407-007-0200 to 407-007-0370 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) The most recent annual audit or review of the child-caring agency required in OAR 413-215-0026(3).

(i) A tax compliance certificate issued by the Oregon Department of Revenue.

(j) Policies required in subsection (3)(j) of this rule.

(k) Other documents or information requested by the Department.

(5) Documents to be submitted to add a program to an existing license. A child-caring agency must submit documents required in subsections (a), (d), (e), (g), (h), (i), (j), (k), (l), (m), (n), and (p) of section (3) of this rule.

(6) 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) A 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.

(7) Processing the Application. Within 30 days of the receipt of an application and the documents described in section (3), (4), or (5) of this rule, the Department will begin its review to determine whether the applicant is or will be in compliance with applicable rules in OAR chapter 413, division 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0086
Licensing Umbrella Rules: 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 applicable rules in OAR chapter 413, division 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 or revoked as provided in OAR 413-215-0121, or rendered invalid when not utilized for a period of six consecutive months.

(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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0091
Licensing Umbrella Rules: 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) Provide copies of all written policies and procedures required in OAR 413-215-0081(3)(j) when requested.

(6) Make reports to the Department as required by law, these rules (OAR 413-215), and upon request to ensure that the requirements for licensing are met.

(7) Provide information about children in care when requested by the Department. 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.

(8) Provide financial records and documents as required by law, these rules (OAR 413-215), and upon request. The Department may request financial information at any time. Information requested may include, but is 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.

(9) Provide the Department with any completed proctor foster home studies as required in OAR 413-215-0316(3) upon request.

(10) 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.

(11) Notify the Department in the following circumstances:

(a) When the child-caring agency employs a new executive director or a new manager of an individual facility or program and when a new board chair or member of the governing board is appointed.

(b) Immediately when information on the "CCA Contact Information Form" changes. An updated form may be submitted electronically or the change may be communicated directly to a Department licensing coordinator.

(c) Within one business day if a critical event occurs. As used in this section, "critical event" means 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 and Oregon Laws 2016, chapter 106.

(d) 30 days or more prior to the voluntary closure or change to inactive status of a program of the child-caring agency.

(e) When services are discontinued or when the child-caring agency intends to reactivate a service after a period of inactivity.

(12) 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.

(13) 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.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0101
Licensing Umbrella Rules: Periodic Inspections

(1) The Department will visit and inspect each licensee and each facility operated by the licensee as provided in this rule to determine whether the program is maintained and operated in accordance with the rules in OAR chapter 413, division 215 and all other applicable laws and rules:

(a) The Department will inspect each child-caring agency at least once every two years; and

(b) 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. Inspections under this subsection will be unannounced and occur at unexpected times and at irregular intervals.

(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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0106
Licensing Umbrella Rules: 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, whether from the inspections undertaken pursuant to ORS 418.255 or otherwise, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0111
Licensing Umbrella Rules: 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 OAR chapter 413, division 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 plan of correction.

(3) The Department may impose conditions on a license as provided in OAR 413-215-0121 while corrections are pending.

(4) If the Department imposes a plan of correction that the child-caring agency does not comply with in the time allotted for correction, the Department must immediately notify the following of the failure 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 governing board and executive director of 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.

(5) 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.

(6) 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.

(7) In addition to the corrective actions in this rule and other rules in OAR chapter 413, division 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0116
Licensing Umbrella Rules: 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 OAR chapter 413, division 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 child-caring agency against whom a civil penalty is to be imposed shall be served a notice of violation and assessment of penalty in the form provided in OAR 137-003-0505 and OAR 137-003-0670. Service of the notice may be accomplished in the manner provided in ORS 411.103.

(9) As provided in ORS 418.993, the child-caring agency to which the notice of violation and assessment of penalty is addressed has 10 days from the date of service of the notice in which to submit 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) If the child-caring agency does not request a hearing, withdraws the hearing request, or fails to appear at the hearing, the Department will issue a final order imposing the penalty.

(11) A civil penalty imposed under this rule is due and payable 10 days after the notice imposing the civil penalty becomes a final order.

(12) If a final order of civil penalty is not appealed or sustained on appeal, and the amount of penalty was not paid within 10 days after the expiration of the appeal deadline, 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.

(13) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0121
Licensing Umbrella Rules: Denial, Suspension, or Revocation of License and Placing Conditions on a License

(1) 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 requirement in OAR chapter 413, division 215.

(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.

(2) Conditions placed on a license under section (1) of this rule include, but are 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.

(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 413-215-0111.

(c) The Department determines at any time during or after an investigation that the 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 requirement in OAR chapter 413, division 215.

(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 more than one program or facility, the Department has the option to suspend, revoke, or deny the license only as it applies to the program or facility out of compliance with applicable statutes or rules.

(8) To request a contested case hearing, as provided in ORS chapter 183, the child-caring agency must provide the Department's Licensing Unit a timely written request for a hearing. If there is no timely written request

for a hearing, the child-caring agency has waived the right to a hearing, except as provided in OAR 137-003-0528(1).

(9) To be timely, a hearing request under section (8) of this rule must be received or postmarked within the following applicable deadline as counted from the date that the Department mailed the notice of denial, suspension, or revocation:

(a) 90 days when the Department previously found a serious danger to the public health or safety and suspended or refused to renew a license with an effective date prior to hearing; or

(b) 30 days when subsection (a) of this section does not apply.

(10) Except for a child-caring agency that retains a facility with an active license under subsection (7) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0126
Licensing Umbrella Rules: 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 OAR chapter 413, division 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 OAR chapter 413, division 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 413-215-0086.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0131
Licensing Umbrella Rules: Exceptions

(1) The Department may waive a requirement of a rule in OAR chapter 413, division 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0201
Academic Boarding Schools: What Law Applies

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..

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0211
Academic Boarding Schools: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0216
Academic Boarding Schools: Physical Plant Requirements

(1) An academic boarding school may not allow children in care to have access to, or provide services regulated by these rules (OAR 413-215-0201 to 413-215-0276) in, a building unless the building has been certified as meeting all applicable state and local construction-related requirements for a building used by the academic boarding school.

(2) An academic boarding school must meet all of the following requirements:

(a) All buildings where children in care are present must be smoke-free.

(b) All buildings owned, maintained, or operated by the academic boarding school to provide services to children in care must meet all applicable state and local building, electrical, plumbing, and zoning codes.

(c) 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.

(d) 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.

(e) Each room used by children in care must be adequate in size and arrangement for the purpose in which it is used.

(f) A system providing a continuous supply of hot and cold water must be distributed to taps conveniently located throughout each facility.

(g) 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.

(h) 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.

(i) 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 413-215-0218, 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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0218
Academic Boarding Schools: Room and Space Requirements

An academic boarding school 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) 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.

(3) 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.

(4) 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 for every eight children in care.

(B) A minimum of one hand-washing sink with mixing faucets for each eight children in care. The sink may not be used for the preparation of food or drinks or for dish washing.

(C) A self-closing metered faucet, if used, that provides water flow for at least 15 seconds without a need to reactivate the faucet.

(D) 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.

(E) One bathtub or shower for every 10 children in care.

(F) Arrangements for individual privacy for each child in care.

(G) A window covering on each window to ensure privacy.

(H) Permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(I) Adequate ventilation.

(J) 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.

(5) 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.

(6) 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 413-215-0236, 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.

(7) 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.

(8) 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.

(9) Outdoor activity area. A usable out-of-doors activity area must be provided that is –

(a) Protected from vehicular traffic and other hazards; and

(b) Of a size and availability appropriate to the age and needs of the children in care.

(10) Classrooms and school buildings, if used, must be adequate in size and arrangement for the programs offered.

(11) 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.

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 22-2016, f. & cert. ef. 12-1-16

413-215-0221
Academic Boarding Schools: Furnishings and Personal Items for Children in Care

An academic 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 individual child in care; and

(d) Towels and washcloths.

(3) Bedding must be changed at least weekly or when soiled and upon change of the child in care.

(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, 418.327, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0226
Academic Boarding Schools: New Facility or Remodel

An academic boarding school must meet all of the following requirements:

(1) Building Plans.

(a) An academic boarding school must submit to the Department for approval a set of plans and specifications for each building used for children in care operated by the academic boarding school 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 an academic boarding school under OAR 413-215-0081.

(b) Plans must comply with all applicable state and local requirements for a building used as a child caring agency, 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 918-750-0115), 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, 418.327, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0231
Academic Boarding Schools: Environmental Health

An academic boarding school must meet all of the following requirements:

(1) The program of the academic 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.: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0236
Academic Boarding Schools: 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 that occur during hours of operation.

(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 record of 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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0241
Academic Boarding Schools: Safety

An academic 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 academic 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 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) 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 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 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:

(i) Covered by an insurance policy in full force and effect;

(ii) Maintained in safe operating condition; and

(iii) Smoke-free.

(B) Each vehicle owned by the academic boarding school and used to transport a child in care must have aboard a first aid kit and a fully charged and working fire extinguisher with a rating of at least 2-A:10-BC.

(C) 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, 418.327, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0246
Academic Boarding Schools: 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;

(d) Dental, vision, hearing, and behavioral health; and

(e) Physician or qualified medical professional's orders, including those related to medication, if any.

(3) Medical examinations. An academic boarding school must safeguard the health of each child in care by providing for a medical examinations of each child by a qualified physical at each of 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.

(4) An academic boarding school must have written procedures for accessing routine and urgent medical care for children in care, including obtaining necessary consents.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0251
Academic Boarding Schools: Medication

An academic boarding school must meet all of the following requirements:

(1) Policy and procedures. The academic boarding school must have and adhere to 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 academic 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) Requirements for the use of herbal supplements and similar remedies; medical treatments such as special diets and physical therapy; and the self-administration of medication by children in care.

(2) 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.

(3) 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.

(4) 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 secured.

(e) Medication must be maintained and stored in its original container, including the prescription label.

(5) 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.

(6) 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 person disposing the medication, and the initials of an adult witness.

(7) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0261
Academic Boarding Schools: Minimum Staffing 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 appropriate 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, Or Laws 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, Or Laws 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0266
Academic Boarding Schools: 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 children in care 18 years of age or older are being served by the academic boarding school.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0271
Academic Boarding Schools: 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.

(c) To allow access to a child in care as required in ORS 418.305 and OAR 413-215-0091 and 413-215-0101.

(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, including, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0276
Academic Boarding Schools: 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.

(5) Any required signed consents and authorizations.

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; CWP 22-2016, f. & cert. ef. 12-1-16

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0311
Foster Care Agencies: 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 program and foster care provided.

(B) The children in care served.

(C) The services provided to the children in care, their families, their proctor foster families, or their approved proctor foster homes.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0313
Foster Care Agencies: 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.

(i) Assure that all adult members of the household:

(A) Possess the ability to exercise sound judgment and demonstrate responsible, stable, emotionally mature behavior, within the individuals' developmental and cognitive abilities;

(B) Do not pose a risk to the safety, health, and well-being needs of a child in care;

(C) Have a lifestyle and personal habit free of criminal activity and abuse or misuse of alcohol or other drugs; and

(D) Cooperate with the foster care agency's assessment of the household.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0316
Foster Care Agencies: 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.

(f) Names and contact information of at least two individuals with whom the applicant is likely to remain in contact if displaced due to a natural disaster.

(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 standards for the proctor foster home environment in OAR 413-215-0318.

(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.

(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 current support systems and need for additional support services.

(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) The proctor foster home applicant's ability to respect the spiritual beliefs, sexual orientation, gender identity and gender expression, disabilities, national origin, and cultural identifies of each child in care, and provide opportunities to enhance the positive self-concept and understanding of the heritage of the child in care.

(r) 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.

(s) 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.

(t) The proctor foster home applicant's home and community.

(u) 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 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0318
Foster Care Agencies: Standards for the Proctor Foster Home Environment

A foster care agency must ensure a proctor foster home meets all of requirement in this rule. This must be documented and kept in the file of the proctor foster home.

(1) General Conditions.

(a) The home must be the primary residence of the applicant or approved proctor foster parent and the residence where the child in care will reside.

(b) The home must have adequate space, including space for safe and appropriate sleeping arrangements, for each child in care.

(A) 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.

(B) Children in care over age 18 years of age or older must be housed in separate bedrooms from children in care under 18 years of age, unless:

(i) A parent and child, one or both of whom is a child in care, share a bedroom; or

(ii) The foster care agency has obtained written approval from the parent or legal guardian and the Department licensing coordinator that two children in care, one over 18 and one under 18 years of age, may share a bedroom.

(C) Unrelated children in care may not share a bed.

(c) The home may not use "electronic monitoring". For purposes of this rule, "electronic monitoring" means the use of video monitoring or listening devices to monitor or record the behavior of a child in care. "Electronic monitoring" does not include:

(A) Door monitors;

(B) Window alarms;

(C) Motion detectors;

(D) Audio or video baby monitors used for a child five years of age and under; or

(E) Monitors approved by a medical provider for medical purposes.

(d) If a child or young adult in the care or custody of the Department will be placed in the proctor foster home, the home must post and comply with the Foster Children's Bill of Rights as required by OAR 413-010-0170 to 413-010-0185.

(e) The applicant or approved proctor foster parent must have access to a working telephone to make and receive phone calls.

(f) The applicant or approved proctor foster parent must consider the age, special needs, and capabilities of the children in care, and have necessary safeguards to assure that:

(A) Swimming pools, hot tubs, wading pools, ponds, and other water hazards are inaccessible to a child in care unless responsibly supervised, and any safeguards comply with state and local ordinances;

(B) Outdoor tools and equipment, machinery, chemicals, flammables, and combustibles are stored in a safe manner;

(C) Animals are safe and appropriate for and are properly cared for and kept in compliance with local ordinances;

(D) Access of a child in care to potentially dangerous animals is restricted; and

(E) Hunting and sporting equipment, such as knives, spears, arrows, hunting sling shots, bows, and martial art weapons are stored in a safe and secure manner and inaccessible to a child in care.

(g) The applicant or approved proctor foster parent must receive authorization from the foster care agency prior to the beginning of hunting or target practice by the child in care.

(2) Sanitation and Health.

(a) If there are potential hazards in or around the home, a plan to prevent the exposure of the child in care to the potential hazard must be developed and approved by the foster care agency.

(b) The home must have the necessary equipment for the safe preparation, storage, serving, and clean-up of food.

(c) The home must have a safe, properly maintained, and operational heating system. Space heaters must be plugged directly into a wall outlet and must be equipped with tip-over protection.

(d) The home and furnishings must be clean and in good repair, and the grounds must be maintained.

(e) There must be no accumulation of garbage or debris.

(f) The home must have safe and adequate drinking water, and an adequate source of safe water to be used for personal hygiene.

(g) There must be provision for the safe storage and administration of all medications in the household, taking into consideration the child's age, developmental level, and need.

(h) There must be easily accessible first aid supplies, and a reasonable understanding of how to use such supplies.

(i) Smoking, tobacco and nicotine limitations:

(A) A child in care may not be exposed to any type of second-hand smoke in the family's home or vehicle; and

(B) A member of the household may not provide any form of tobacco, nicotine, or other product illegal for a minor to possess to a child in care.

(C) All products referenced in paragraph (B) of this subsection must be stored in a safe and secure manner inaccessible to a child in care.

(3) Fire and Carbon Monoxide Safety.

(a) The home must have all of the following:

(A) A working smoke alarm in each bedroom where a child in care sleeps within 24 hours of the time the applicant is certified or approved.

(B) A working carbon monoxide detector within 15 feet of each bedroom where a child in care sleeps and at least one on each floor within 24 hours of the time the applicant is certified or approved.

(C) At least one operable fire extinguisher rated 2-A:10-B-C or higher within 24 hours of the time the applicant is certified or approved.

(D) At least one means of emergency exit and at least one means of rescue from the home.

(E) An adequate safeguard around operating fireplaces, wood stoves, or other heating systems that may cause burns to a child in care that is developmentally unable to reasonably follow safety rules regarding such devices.

(F) A written, comprehensive home evacuation plan, shared with each child in care at the time of placement, and practiced at least every six months. The written, comprehensive home evacuation plan must include a provision for the safe exit of a child in care who is not capable of understanding or participating in the evacuation plan.

(G) Interior doors that lock must be operable from both sides of the door.

(b) Each bedroom used by a child in care must have:

(A) At least one unrestricted exit;

(B) At least one secondary means of exit or rescue;

(C) Smoke alarms required under paragraph (3)(a)(A) of this rule;

(D) Unrestricted, direct access at all times to hallways, corridors, living rooms, or other such common areas; and

(E) Quick release mechanisms on all barred windows.

(4) Travel and Transportation Safety.

(a) An applicant or approved proctor foster parent must have available, and be willing to use, a safe and reliable method of transportation.

(b) Any member of the household transporting a child in care must provide proof of a valid driver's license and current insurance on any family-owned motorized vehicle by which a child in care might be transported, when a family has applied for certification or renewal of certification.

(c) The applicant or approved proctor foster parent must assure that, as required by current state law:

(A) Only a licensed and insured driver transports a child in care in motorized vehicles; and

(B) A child in care uses a seat belt or age and size appropriate safety seat when transported in motorized vehicles.

(d) Written authorization from the foster care agency must be received by the proctor foster home prior to transporting a child in care out of the State of Oregon or outside the United States.

(e) A proctor foster home must request approval from the Department no less than 90 days prior to any international travel with a child in care. In an emergency, the proctor foster home must request approval from the foster care agency as soon as the need for international travel becomes known.

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 22-2016, f. & cert. ef. 12-1-16

413-215-0321

Foster Care Agencies: Orientation for Proctor Foster 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 described in OAR 413-215-0311.

(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 if the applicant has received the orientation described in section (2) 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 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0326

Foster Care Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0331
Foster Care Agencies: 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 12 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 413-215-0316(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 in OAR 413-215-0318.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0336
Foster Care Agencies: 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 as soon as is appropriate, based on the nature of the complaint.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0341
Foster Care Agencies: 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.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0349
Foster Care Agencies: 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 or medication 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0351
Foster Care Agencies: Records of Proctor Foster 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) Whether the applicant has been approved and a certificate or certificate renewal 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.

(b) Whether the foster care agency has provided the notification described in OAR 413-215-0316(4).

(c) All documents pertaining to approval of the proctor foster home.

(d) All documents pertaining to formal complaints about the proctor foster home.

(e) The contract between the foster care agency and the parents in the proctor foster home.

(f) A list of all children in care placed in the proctor foster home that includes identifying and placement information.

(g) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0356

Foster Care Agencies: 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) 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.

(6) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0361

Foster Care Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0366

Foster Care Agencies: Respite Care

A foster care agency must comply with all of the following requirements:

(1) The foster care agency must have and adhere to a respite care policy 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) annually for the alternate caregiver and, if respite care will be provided in the home of the alternate caregiver, all adults living in the home of the alternate caregiver; 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0371

Foster Care Agencies: Training of Foster Care Agency Staff

In addition to the 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) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0376

Foster Care Agencies: 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 192.553 to 192.573;

(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 written procedures for accessing routine and urgent medical care for children in care, including obtaining necessary consents.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0381

Foster Care Agencies: 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.

(h) How the foster care agency and the proctor foster home will ensure compliance with OAR 413-070-0470 if it serves children in Department custody.

(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 person 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0386

Foster Care Agencies: Referral and Initial Evaluation of Children in Care

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0391
Foster Care Agencies: 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 and 413-215-0101.

(e) To allow access to a child in care as required in ORS 418.305 and OAR 413-215-0091 and 413-215-0101.

(f) To impose a dress code.

(g) 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 foster care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0396
Foster Care Agencies: 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.

(f) Any required signed consents and authorizations.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0411
Adoption Agencies: 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 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, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0416
Adoption Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0421
Adoption Agencies: Staff Training Requirements

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.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0426
Adoption Agencies: Policies and Procedures

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 for adoption;

(b) A child who becomes available for adoption; and

(c) A family who adopts a child.

(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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0431
Adoption Agencies: 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 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, the name and address of the hospital or birthing center if the child 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's birth, including age, height, weight, and color of eyes, hair and skin.

(h) Personality traits of the child'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, 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'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'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 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'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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0436
Adoption Agencies: Services Prohibited

An adoption agency may not guarantee or represent to prospective adoptive parents that a particular child 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0441
Adoption Agencies: 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 within 60 days of the court proceeding about the adoption or custody of the child;

(B) The putative father repeatedly contributed or tried to contribute to the support of the child within 12 months of the court proceeding about the adoption or custody of the child; 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, 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.

(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 and the adopting parents after adoption, the variables and options for such continuing contact, the desire of the child 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.

(3) The adoption agency must provide guidance if a child'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'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 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 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, 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'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 with a member of the child'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 with a family based solely on preferred race, color, or national origin unless the child is an Indian child, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0446
Adoption Agencies: 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 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 and ways to foster these identities.

(e) The effects of adoption on the child 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0451
Adoption Agencies: Adoptive Home Requirements

(1) Home study. Before an adoption agency approves a family for an adoptive placement and before referring or placing a child 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 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 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) Signed release of information to determine if the applicant has been denied or revoked certification with another adoption agency or by the Department.

(u) 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.

(v) 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.

(w) An assessment of all the information gathered regarding the adoptive applicants and any recommendations.

(x) 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.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0456
Adoption Agencies: 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'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 under consideration before the earliest of the following:

(a) The child is placed with them.

(b) Travel to the child'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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0461
Adoption Agencies: Evaluation and Selection of Adoptive Family

An adoption agency must meet all of the following requirements regarding the placement of a child:

(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.

(b) The child's need for continued contact with siblings, relatives, foster parents, and other persons significant to the child.

(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, the adoption agency must select an adoptive family who is approved by an adoption agency, consistent with the needs of the child 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0466
Adoption Agencies: Domestic Adoptive Placement 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. The plan must include provisions for pre-placement visits with the prospective adoptive family.

(2) Placement agreement documents. Before placing the child 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;

(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;

(c) That the pre-adoptive parents agree to participate in supervision by the adoption agency, based on the best interests of the child, 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 from the state for more than 72 hours.

(C) Placement of the child 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 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 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'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.

(4) Child and birth parent information. Before placing a child 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 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'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.

(6) Post-placement supervision. The adoption agency is responsible for the child until the court has entered the general judgment of adoption. After the child 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's age and special needs, and the family's adjustment to the child.

(b) Any change in the adoptive family relating to health, finances, or composition that could affect the child.

(c) Providing to the adoptive parents any medical information on a child's birth family received by the adoption agency after the child 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0471
Adoption Agencies: Adoption Finalization 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0476
Adoption Agencies: 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 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 10 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 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 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's country of origin that the necessary consents to the child'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.

(c) The child has the proper emigration and immigration permits.

(d) The authorized service or person has the child'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's country of origin to make reasonable efforts, to obtain and provide all available information concerning a child 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 and the reasons why the child is in custody.

(b) Information concerning the child's history, including a chronology showing the persons and institutions that have had custody of and cared for the child, the nature of care provided, and the reasons for transferring custody.

(c) Information concerning the child's immediate family, including current status and location of the birth parents and siblings of the child; history of abuse, neglect, or mistreatment of the child; history of alcohol and drug abuse by the birth parents; hereditary conditions; and other risk factors.

(d) Information concerning the child's cultural, racial, religious, ethnic, and linguistic background.

(e) The child'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.

(C) A history of significant illnesses or medical events, hospitalizations, and changes in the child's condition, growth data, and developmental status at the time of the child's referral for adoption.

(f) Videotapes and photographs of the child, 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 resides.

(5) An adoption agency must provide the information described in section (4) of this rule to prospective adoptive parents regarding a child 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 until the prospective adoptive parents have had at least one week to consider the needs of the child and their ability to meet those needs, and to obtain medical review of child information. The adoption agency may withdraw the referral earlier if the best interests of the child 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 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 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 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 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'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 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 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.

(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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0481

Adoption Agencies: Services to Children from the United States Placed in Other Countries

Before making a plan to place a child 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; CWP 22-2016, f. & cert. ef. 12-1-16

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0511

Residential Care Agencies: 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 by the residential care agency.

(2) A residential care agency must meet all of the following requirements:

(a) All buildings where children in care are present must be smoke-free.

(b) All buildings owned, maintained, or operated by the residential care agency to provide services to children in care must meet all applicable state and local building, electrical, plumbing, and zoning codes.

(c) 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.

(d) 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.

(e) Each room used by children in care must be adequate in size and arrangement for the purpose in which it is used.

(f) A system providing a continuous supply of hot and cold water must be distributed to taps conveniently located throughout each facility.

(g) 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.

(h) 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.

(i) 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.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0516

Residential Care Agencies: 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) 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.

(3) 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.

(4) 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 for every eight children in care.

(B) A minimum of one hand-washing sink with mixing faucets for every eight children in care. The sink may not be used for the preparation of food or drinks or for dish washing.

(C) A self-closing metered faucet, if used, that provides water flow for at least 15 seconds without a need to reactivate the faucet.

(D) 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.

(E) One bathtub or shower for every 10 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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.

(9) Outdoor activity area. A usable out-of-doors activity area must be provided that is:

(a) Protected from vehicular traffic and other hazards.

(b) Of a size and availability appropriate to the age and needs of the children in care.

(10) Classrooms and school buildings, if used, must be adequate in size and arrangement for the programs offered.

(11) 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.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0521
Residential Care Agencies: Furnishings and Personal Items

A residential care agency 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 individual resident's comfort; and

(d) Towels and washcloths.

(3) Bedding must be changed at least weekly or 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0526
Residential Care Agencies: 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 building used for children in care 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 918-750-0115), 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0531
Residential Care Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0536
Residential Care Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0541
Residential Care Agencies: 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) 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:

(i) Covered by an insurance policy in full force and effect;

(ii) Maintained in safe operating condition; and

(iii) Smoke-free.

(B) Each vehicle owned by the residential care agency and used to transport a child in care must have aboard a first aid kit and a fully charged and working fire extinguisher with a rating of at least 2-A:10-BC.

(C) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0546
Residential Care Agencies: 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 residential 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 written procedures for accessing routine and urgent medical care for children in care, including obtaining necessary consents.

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0551
Residential Care Agencies: 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.

(h) How the foster care agency and the proctor foster home will ensure compliance with OAR 413-070-0470 if it serves children in Department custody.

(2) 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.

(3) 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.

(4) A written approval, signed by a physician or qualified medical professional, is required for any use of herbal supplements or remedies.

(5) 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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 person disposing the medication, and the initials of an adult witness.

(10) 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.

(11) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0554
Residential Care Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0556
Residential Care Agencies: Staff Training

In addition to the requirements in OAR 413-215-0061(4) and (5), 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0561
Residential Care Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0566
Residential Care Agencies: Separation of Residents

A residential care agency must meet all of the following requirements:

(1) Combining children and adults. Children in care 18 years of age or older must be housed in separate bedrooms from children in care under 18 years of age, unless:

(a) A parent and child, when one or both is a child in care, share a bedroom; or

(b) The residential care agency has obtained written approval from the parent or legal guardian and the Department licensing coordinator that two children in care, one over 18 and one under 18 years of age, may share a bedroom.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0571
Residential Care Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0576
Residential Care Agencies: 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 and 413-215-0101.

(e) To allow access to a child in care as required in ORS 418.305 and OAR 413-215-0091 and 413-215-0101.

(f) To impose a dress code.

(g) 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 access to a child in care must be provided as required in ORS 418.305 and OAR 413-215-0091 and 413-215-0101.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0581
Residential Care Agencies: 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 and current 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.

(f) Any required signed consents and authorizations.

(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 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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0586
Residential Care Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0611

Therapeutic Boarding Schools: 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 15 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0616

Therapeutic Boarding Schools: Physical Plant Requirements

(1) A therapeutic boarding school may not allow children in care to have access to, or provide services regulated by these rules (OAR 413-215-0601 to 413-215-0681) in, a building unless the building has been certified as meeting all applicable state and local construction-related requirements for a building used by the therapeutic boarding school.

(2) A therapeutic boarding school must meet all of the following requirements:

(a) All buildings where children in care are present must be smoke-free.

(b) 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.

(c) 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.

(d) 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.

(e) Each room used by children in care must be adequate in size and arrangement for the purpose in which it is used.

(f) A system providing a continuous supply of hot and cold water must be distributed to taps conveniently located throughout each facility.

(g) 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.

(h) 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.

(i) 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 413-215-0618 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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0618

Therapeutic Boarding Schools: Room and Space Requirements

A therapeutic boarding school 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) 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.

(3) 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.

(4) 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 for every eight children in care.

(B) A minimum of one hand-washing sink with mixing faucets for each eight children in care. The sink may not be used for the preparation of food or drinks or for dish washing.

(C) A self-closing metered faucet, if used, that provides water flow for at least 15 seconds without a need to reactivate the faucet.

(D) 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.

(E) One bathtub or shower for every 10 children in care.

(F) Arrangements for individual privacy for each child in care.

(G) A window covering on each window to ensure privacy.

(H) Permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(I) Adequate ventilation.

(J) 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.

(5) 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.

(6) 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 413-215-0636, 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.

(7) 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.

(8) 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.

(9) Outdoor activity area. A usable out-of-doors activity area must be provided that is:

(a) Protected from vehicular traffic and other hazards; and

(b) Of a size and availability appropriate to the age and needs of the children in care.

(10) Classrooms and school buildings, if used, must be adequate in size and arrangement for the programs offered.

(11) 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.

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 22-2016, f. & cert. ef. 12-1-16

413-215-0621
Therapeutic Boarding Schools: Furnishings and Personal Items for Children in Care

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 individual child in care; and

(d) Towels and washcloths.

(3) Bedding must be changed at least weekly or 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 in care's age, gender, and culture must be made available for 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 age, gender, and cultural needs of the child in care.

(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, 418.327, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0626
Therapeutic Boarding Schools: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0631
Therapeutic Boarding Schools: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0636
Therapeutic Boarding Schools: 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 that occur during hours of operation.

(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 record of the therapeutic boarding school 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:

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0641
Therapeutic Boarding Schools: 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) 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.

(b) Vehicle requirements.

(A) Each vehicle used to transport a child in care served by the therapeutic boarding school must be:

(i) Covered by an insurance policy in full force and effect;

(ii) Maintained in safe operating condition; and

(iii) Smoke-free.

(B) Each vehicle owned by the therapeutic boarding school and used to transport a child in care must have aboard a first aid kit and a fully charged and working fire extinguisher with a rating of at least 2-A:10-BC.

(C) 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, 418.327, 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0646
Therapeutic Boarding Schools: Health Services

(1) A therapeutic 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 with a therapeutic boarding school, the therapeutic 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, within ORS 192.553 to 192.573;

(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 medication, if any.

(3) 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.

(4) Medical examinations. A therapeutic boarding school 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 therapeutic boarding school must have written procedures for accessing routine and urgent medical care for children in care, including obtaining necessary consents.

(6) A therapeutic boarding school must ensure each child in care receives services from a Qualified Mental Health Professional (QMHP) at least once every 30 days and ensure 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0651
Therapeutic Boarding Schools: 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) 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.

(3) 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.

(4) A written approval, signed by a physician or qualified medical professional, is required for any use of herbal supplements or remedies.

(5) 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.

(6) Before a therapeutic boarding school 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 therapeutic boarding school.

(7) 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 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.

(8) 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.

(9) 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 person disposing the medication, and the initials of an adult witness.

(10) 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 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.

(11) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0656
Therapeutic Boarding Schools: Staff Training

In addition to the requirements in OAR 413-215-0061(4) and (5), 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0661
Therapeutic Boarding Schools: 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 staff 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 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 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0666

Therapeutic Boarding Schools: Separation of Children in Care

A therapeutic boarding school must meet all of the following requirements:

(1) Combining children and adults. Children in care 18 years of age or older must be housed in separate bedrooms, unless:

(a) A parent and child, when one or both is a child in care, share a bedroom; or

(b) The therapeutic boarding school has obtained written approval from the parent or legal guardian and the Department licensing coordinator that two children in care, one over 18 and one under 18 years of age, may share a bedroom.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0671

Therapeutic Boarding Schools: 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. 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0676

Therapeutic Boarding Schools: 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 and 413-215-0101.

(e) To allow access to a child in care as required in ORS 418.305 and OAR 413-215-0091 and 413-215-0101.

(f) To impose a dress code.

(g) 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.

(e) A statement of program services that will be available to the child in care, including frequency of services and the professional credentials of the service providers.

(f) A statement that the child-caring agency may not make limitation on contact between a child and his or her parent or legal guardian a condition of program participation.

(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, except that access to the child in care must be provided as required in ORS 418.305 and OAR 413-215-0091 and 413-215-0101.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0681

Therapeutic Boarding Schools: Information about Children in Care

(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.

(f) Any required signed consents and authorizations.

(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 by a Qualified Mental Health Professional (QMHP). This assessment must include all of the following:

(A) 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.

(B) Suicide potential must be assessed and the record 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. When the assessment determines the presence of co-occurring disorders, the therapeutic boarding school must document referral for further assessment, planning, and intervention from an appropriate professional.

(D) Screening for the presence of symptoms related to physical or psychological trauma.

(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 a QMHP 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; CWP 22-2016, f. & cert. ef. 12-1-16

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 children in care working towards independent living.

(2) A child-caring agency that provides residential services for homeless or runaway youth pregnant or parenting girls, or other children in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0711
Homeless, Runaway, and Transitional Living Shelters: Governance

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0716
Homeless, Runaway, and Transitional Living Shelters: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0721
Homeless, Runaway, and Transitional Living Shelters: 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 413-215-0726.

(3) A child-caring agency must have a ratio of staff to children in care that is sufficient to ensure that children in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0726

Homeless, Runaway, and Transitional Living Shelters: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0731

Homeless, Runaway, and Transitional Living Shelters: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0736

Homeless, Runaway, and Transitional Living Shelters: 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 child in care'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 child in care'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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0741

Homeless, Runaway, and Transitional Living Shelters: Client Files

(1) General requirements. Except with respect to children in care in a mass shelter service plan operated by the child-caring agency, a child-caring 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 child-caring 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 child-caring 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0746

Homeless, Runaway, and Transitional Living Shelters: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0751

Homeless, Runaway, and Transitional Living Shelters: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0756

Homeless, Runaway, and Transitional Living Shelters: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0761

Homeless, Runaway, and Transitional Living Shelters: 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 children in care. 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 children in care.

(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 918-750-0115), 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0766
Homeless, Runaway, and Transitional Living Shelters: 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; CWP 22-2016, f. & cert. ef. 12-1-16

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. A day treatment agency must:

(a) Comply with OAR 413-215-0001 to 413-215-0131 and OAR 413-215-0801 to 413-215-0856; and

(b) Comply with all requirements in OAR chapter 309, division 22 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0811
Day Treatment Agencies: 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 309-022-0125.

(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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0816
Day Treatment Agencies: 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 (OAR 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0821

Day Treatment Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0826

Day Treatment Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0831

Day Treatment Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0836
Day Treatment Agencies: 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:

(i) Covered by an insurance policy in full force and effect;

(ii) Maintained in safe operating condition; and

(iii) Smoke-free.

(B) Each vehicle owned by the day treatment agency and used to transport a child in care must have aboard a first aid kit and a fully charged and working fire extinguisher with a rating of at least 2 A:10 BC.

(C) 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0841
Day Treatment Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0846
Day Treatment Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0851

Day Treatment Agencies: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0856

Day Treatment Agencies: 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 15 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0901

Outdoor Youth Programs: 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. 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0916

Outdoor Youth Programs: 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)).

(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, 24 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 child in care'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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0918
Outdoor Youth Programs: 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)(d).

(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)(c).

(e) To allow access to a child in care as required in ORS 418.305 and OAR 413-215-0091 and 413-215-0101.

(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 child in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0921
Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0926
Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0931
Outdoor Youth Programs: 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) Children in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0936

Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0941

Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0946

Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0951

Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0956

Outdoor Youth Programs: Transportation

(1) Vehicle. Transportation of children in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0961

Outdoor Youth Programs: 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 child in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0966

Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0971

Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0976

Outdoor Youth Programs: 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 child in care is exhibiting signs of exhaustion or fatigue. The 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0981
Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0986
Outdoor Youth Programs: 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 12 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 children in care;

(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 10 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 14 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0991
Outdoor Youth Programs: 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 10 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 child in care.

(3) Placement of youth age 10 years through 12 years. An outdoor youth program may place children in care 10 years of age through 12 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 10 years of age through 12 years of age in an older group, an assigned staff member with documented experience placing children in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0992
Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-0996
Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-1001
Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-1006
Outdoor Youth Programs: Field 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 child in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-1011
Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-1016
Outdoor Youth Programs: 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 child in care'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, Or Laws 2016, ch 106
Stats. Implemented: ORS 409.010, 418.205 - 418.325, Or Laws 2016, ch 106
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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-1021
Outdoor Youth Programs: 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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-1026
Outdoor Youth Programs: Solo Experiences

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; CWP 22-2016, f. & cert. ef. 12-1-16

413-215-1031
Outdoor Youth Programs: 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 15 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 child in care 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; CWP 22-2016, f. & cert. ef. 12-1-16

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Rules Repealed: 413-015-0100(T), 413-015-0125(T), 413-015-0205(T), 413-015-0212(T), 413-015-0300(T), 413-015-0409(T), 413-015-0420(T), 413-015-0440(T), 413-015-0445(T), 413-015-0450(T), 413-015-0620(T), 413-015-0625(T), 413-015-0630(T), 413-015-0640(T), 413-015-1000(T), 413-015-9030(T), 413-015-9040(T), 413-080-0050(T), 413-080-0051(T), 413-080-0052(T), 413-080-0054(T), 413-080-0059(T), 413-080-0070(T), 413-090-0000(T), 413-090-0055(T), 413-090-0065(T), 413-090-0070(T), 413-090-0075(T), 413-090-0080(T), 413-090-0090(T)
Subject: The Department is adopting and amending rules to improve the oversight by the Department of child-caring agencies and proctor foster homes, promote the safety of children residing in or receiving services from child-caring agencies licensed by the Department as well as proctor foster homes, and comply with and implement SB 1515 (Oregon Laws 2016, chapter 106.) A proctor foster home means a foster home certified by a child-caring agency. Most of these rule changes have been in place as temporary rules that took effect July 1, 2016.

Child Protective Services

The Department is changing the rules setting requirements for screeners and CPS (Child Protective Services) workers when reports of abuse or neglect are received by the Department to state that when a report is received and the information indicates it involves a child-caring agency or proctor foster home, screeners will follow OAR 413-015-0620 through 413-015-0640. Under these rule changes, reports will be screened under a new definition of abuse (from 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

The Department is changing the rules describing its responsibilities 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 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 being 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

The Department is changing rules describing the requirements for BRS (Behavior Rehabilitation Services) contractors who provide BRS services to children to require the Department's Well Being Unit to investigate reports regarding child-caring agencies 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 laws and regulations, including new SB 1515 licensing requirements in OAR chapter 413, division 215.

Additional edits were made to the rules described above 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.

Links to the rule text showing the changes described above, along with other rule changes being made to implement SB 1515 for the Office of Licensing and Regulatory Oversight, the Office of Adult Abuse Prevention and Investigations, and the Background Check Unit, are available at http://www.dhs.state.or.us/policy/childwelfare/policy_releases.htm. More information about the implementation of SB 1515 is available 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; CWP 23-2016, f. & cert. ef. 12-1-16

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 or proctor foster home.

(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 means a "child-caring agency" that is not owned, operated, or administered by a governmental agency or unit.

(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.

(29) "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.

(39) "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) "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.

(51) "Substance" means any controlled substance as defined by ORS 475.005, prescription medications, over-the-counter medications, or alcoholic beverages.

(52) "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.

(53) "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.

(54) "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.

(55) "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.

(56) "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.

(57) "Unsafe" means the presence of a present danger safety threat or an impending danger safety threat.

(58) "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.

(59) "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, OL 2016, ch 106

Stats. Implemented: ORS 147.425, 409.185, 418.005, 418.015, 418.747, 419B.005 - 419B.050, OL 2016, ch 106

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; CWP 17-2016, f. & cert. ef. 9-29-16; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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 involves a child-caring agency or proctor foster home, the screener must immediately comply with "Department Responsibilities When a Report 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, OL 2016, ch 106

Stats. Implemented: ORS 418.005 & 419B.020, OL 2016, ch 106

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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

413-015-0620
Purpose

The purpose of OAR 413-015-0620 to 413-015-0640 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; CWP 23-2016, f. & cert. ef. 12-1-16

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 of 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) "Chemical restraint" means the administration of medication for the management of uncontrolled behavior. "Chemical restraint" is different from the use of medication for treatment of symptoms of severe emotional disturbances or disorders.

(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 418.327, 418.475 or 418.950 to 418.970.

(4) "Financial exploitation" means:

(a) 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.

(5) "Intimidation" means compelling or deterring conduct by threat. "Intimidation" does not include age-appropriate discipline that may involve the threat to withhold privileges.

(6) "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.

(7) "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.

(8) "Seclusion" means that a child in care is involuntarily confined to an area or room, and is physically prevented from leaving.

(9) "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.

(10) "Sexual contact" has the meaning given that term in ORS 163.305(1)(a)(E).

(11) "Sexual exploitation" as described in ORS 419B.005(1)(a)(E).

(12) "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; CWP 23-2016, f. & cert. ef. 12-1-16

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 OAAPI determines the response to information alleging abuse of a child or young adult who receives services from a child-caring agency when the alleged 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.

(b) 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.

(2) When a screener determines the report is the responsibility of the OAAPI as outlined in subsection (1)(a) of this rule, the following requirements apply:

(a) The screener must immediately pend the screening information to the OAAPI screener's workload.

(b) The screener must immediately send an e-mail to the OAAPI to let the OAAPI know that a screening report has been assigned to the OAAPI screener's workload.

(c) When only subsection (1)(a) of this rule applies, screening activities are complete.

(3) When a screener determines the report is the responsibility of the Department as outlined in subsection (1)(b) of this rule, the following requirements apply:

(a) The screener must comply with OAR 413-015-0205 to 413-015-0225.

(b) The screener must immediately report to Department personnel assigned to ensure notifications outlined in Oregon Laws 2016, chapter 106 and OAR 413-080-0070 when the report:

(A) Meets the criteria to close at screening or assign for CPS assessment; or

(B) Does not meet the criteria to close at screening or assign for CPS assessment, but includes a concern about a child-caring agency or proctor foster home.

(c) The screener must document the date the report was made and the method for making the report outlined in subsection (b) of this section in the Department's electronic information system's case notes when possible.

(4) When both subsections (1)(a) and (1)(b) of this rule apply, complete the requirements in this rule in two screening report forms.

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; CWP 23-2016, f. & cert. ef. 12-1-16

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 ensure 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 Department Well Being compliance specialist or designee when the child-caring agency or proctor foster home has a contract to provide Behavior Rehabilitation Services; and

(D) An OAAPI investigator, if assigned.

(c) The CPS supervisor or designee must:

(A) Ensure 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, ensure 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 to 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 foster home. When this individual is also an alleged perpetrator, provide additional notification to an additional person responsible for the child-caring agency or proctor foster home. The CPS worker must meet with the owner, manager, operator, or appropriate authority responsible for the child-caring agency or proctor foster 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) When the alleged abuse or neglect occurred in a proctor foster home all adults and all children residing in the proctor foster home must be interviewed.

(F) 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 OAR 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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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) Ensure one of the following applies:

(A) Any of the criteria outlined in OAR 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) Ensure 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, dis-

cuss 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; CWP 23-2016, f. & cert. ef. 12-1-16

413-080-0050
Definitions

Unless the context indicates otherwise, the following definitions apply to OAR chapter 413, division 080:

(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 means a "child-caring agency" that is not owned, operated, or administered by a governmental agency or unit.

(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.

(7) "Face-to-face" means an in-person interaction between individuals.

(8) "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.

(9) "Guardian" means an individual who has been granted guardianship of a child through a judgment of the court.

(10) "ICPC" means the Interstate Compact for the Placement of Children (see ORS 417.200).

(11) "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.

(12) "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.

(13) "Monthly face-to-face contact" means in-person interaction between individuals at least once each and every full calendar month.

(14) "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.

(15) "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.

(16) "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.

(17) "Proctor foster home" means a foster home certified by a child-caring agency that is not subject to ORS 418.625 to 418.645.

(18) "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.

(19) "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.

(20) "Provider" means an employee of a child-caring agency approved to provide care for a child in care or a proctor foster parent.

(21) "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.

(22) "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.

(23) "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.

(24) "Screener" means a Department employee with training required to provide screening services.

(25) "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.

(26) "Social service assistant" means a Department employee with training required to provide services to assist a caseworker on an open case.

(27) "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.

(28) "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; CWP 23-2016, f. & cert. ef. 12-1-16

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 young adult 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 young adult 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; CWP 23-2016, f. & cert. ef. 12-1-16

413-080-0052
Addressing a Concern in a Child-Caring Agency or Proctor Foster Home

(1) When Department staff become aware of a concern involving a child-caring agency or proctor foster home, staff must immediately:

(a) Report to 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 date the report was made and the method for making the report in the Department's electronic information system's case notes when possible; and

(c) Make efforts to address the concern for the child or young adult.

(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; CWP 23-2016, f. & cert. ef. 12-1-16

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 when:

(i) There is any concern about the safety of a child or young adult; or

(ii) There is any concern about a child-caring agency or proctor foster home, including the well-being needs of a child in care not being met by a child-caring agency or proctor foster parent.

(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.

(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; CWP 23-2016, f. & cert. ef. 12-1-16

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 young adult, 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 young adult 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 young adult 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 young adult.

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; CWP 23-2016, f. & cert. ef. 12-1-16

413-080-0070
Notifications When Reports Are Made Regarding Child Safety or Compliance in a Child-Caring Agency or Proctor Foster Home

(1) The Department must notify appropriate parties as provided in Oregon Laws 2016, chapter 106 and this rule when:

(a) The Department receives a report of a suspected violation by a child-caring agency or proctor foster home;

(b) When the Department receives a report of abuse of a child in care;

(c) When a report of abuse of a child in care is substantiated or founded; and

(d) When the Department places conditions on a license or suspends or revokes a license under OAR 413-215-0121.

(2) Report of suspected violation.

(a) A report is a suspected violation when the report includes information that the child-caring agency or proctor foster home may have failed to comply with a requirement:

(A) In ORS 418.240;

(B) Applicable to the child-caring agency in OAR 413-215-0000 to 413-215-1031;

(C) Applicable to the child-caring agency in OAR 413-090-0055 to 413-090-0090; or

(D) In a contract the child-caring agency has with the Department.

(b) When information received is a suspected violation under subsection (a) of this section, the Department must notify:

(A) Appropriate Department personnel including, but not limited to:

(i) Personnel responsible for investigating complaints under OAR 413-215-0106; and

(ii) Personnel responsible for ensuring contract compliance under OAR 413-090-0090.

(B) Any governmental agency or unit that has a contract with the child-caring agency to provide services to a child.

(C) A contact person designated by the child-caring agency as the authority responsible for such reports.

(3) Report of abuse of a child in care.

(a) When the report is a report of abuse of a child in care, the Department must notify all of the following:

(A) Appropriate Department personnel including, but not limited to:

(i) Personnel responsible for licensing child-caring agencies and investigating complaints under OAR 413-215-0106;

(ii) Personnel responsible for ensuring contract compliance under OAR 413-090-0090; and

(iii) The caseworker for the child in care named in the report.

(B) Any governmental agency or unit that has a contract with the child-caring agency to provide services to the child in care named in the report.

(C) A contact person designated by the child-caring agency as the authority responsible for such reports.

(D) The attorney for the child in care.

(E) The court appointed special advocate for the child in care.

(F) The parents or guardians of the child in care.

(G) The attorney representing the parent or guardian of the child in care.

(b) When a report of abuse of a child in care is substantiated or founded the Department must notify all of the following persons and entities of the disposition:

(A) The Director of the Department.

(B) Department personnel responsible for licensing child-caring agencies.

(C) The Director of the Office of Child Welfare Programs.

(D) The caseworker for the child in care.

(E) The court appointed special advocate, if any, for the child in care.

(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 the Department 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 the Department 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.

(J) The governing board for the child-caring agency.

(4) When the Department places conditions on a license, or suspends or revokes a license under OAR 413-215-0121, the Department must notify:

(a) Any governmental agency or unit that has a contract with the child-caring agency to provide care or services to a child; and

(b) The governing board for the child-caring agency.

(5) Information provided under this rule may only be disclosed consistent with state and federal law and Department rules. Information may not be disclosed if disclosure would hinder an investigation or place a child at risk.

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; CWP 23-2016, f. & cert. ef. 12-1-16

413-090-0000
Definitions

Unless the context indicates otherwise, the following definitions apply to rules in OAR chapter 413, division 90:

(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 responsibilities 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.

(38) "SAIP" means Secure Adolescent Inpatient Program.

(39) "SCIP" means Secure Children's Inpatient Program.

(40) "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.

(41) "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.

(42) "Transitional visit" means an overnight visit by the BRS client to another placement for the purpose of facilitating the BRS client's transition.

(43) "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; CWP 23-2016, f. & cert. ef. 12-1-16

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 December 1, 2016, and the Agency-specific BRS program rules that are effective on December 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; CWP 23-2016, f. & cert. ef. 12-1-16

413-090-0065
Definitions

Definitions for OAR 413-090-0055 to 413-090-0090 are in OAR 413-090-0000 and OAR 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; CWP 23-2016, f. & cert. ef. 12-1-16

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; CWP 23-2016, f. & cert. ef. 12-1-16

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 is in the care or custody of the Department or a federally recognized tribe in Oregon and is denied prior authorization for the BRS program under subsection (1)(a) of this rule, the child in care is entitled to notice and contested case hearing rights under OAR 410-120-1860 to 410-120-1865. The contested case hearing will be provided by the Authority (see OAR 410-120-1860(1)) and conducted by the Office of Administrative Hearings (see ORS 183.635).

(b) When a child in care is in the care or custody of the Department and enrolled in the Oregon Health Plan is denied prior authorization for the BRS program under subsection (1)(b) of this rule, the child in care is entitled to notice and contested case hearing rights under OAR 413-010-0500 to 413-010-0535. The contested case hearing will be provided by the Department and conducted by the Office of Administrative Hearings (see ORS 183.635).

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; CWP 23-2016, f. & cert. ef. 12-1-16

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 com-

plete 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; CWP 23-2016, f. & cert. ef. 12-1-16

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) 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.

(5) 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; CWP 23-2016, f. & cert. ef. 12-1-16

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Department of Human Services, Self-Sufficiency Programs
Chapter 461

Rule Caption: Adopting rule relating to Achieving a Better Life Experience (ABLE) accounts
Adm. Order No.: SSP 43-2016
Filed with Sec. of State: 12-7-2016
Certified to be Effective: 12-28-16
Notice Publication Date: 11-1-2016
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 (26 USC 529A) and ORS 178.380(3) (SB 777 (2015)) 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). This makes permanent a temporary rule adopted on June 30, 2016.
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 Qualified Disability Expenses (see section (2) of this rule) are counted as unearned income.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.083, 411.404, 411.816, 412.049
Stats. Implemented: ORS 178.375, 178.380, 409.050, 411.060, 411.070, 411.083, 411.404, 411.816, 412.049
Hist.: SSP 26-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16; SSP 43-2016, f. 12-7-16, cert. ef. 12-28-16

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Rule Caption: Amending rules relating to public and medical assistance programs
Adm. Order No.: SSP 44-2016
Filed with Sec. of State: 12-7-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 10-1-2016, 11-1-2016, 12-1-2016
Rules Adopted: 461-145-0035, 461-145-0417
Rules Amended: 461-120-0345, 461-135-0730, 461-135-0780, 461-135-0820, 461-140-0296, 461-145-0005, 461-145-0140, 461-145-0220, 461-145-0550, 461-145-0930, 461-150-0050, 461-155-0250, 461-155-0270, 461-155-0300, 461-160-0580, 461-160-0620, 461-180-0050
Rules Repealed: 461-140-0296(T), 461-145-0184
Subject: OAR 461-120-0345 is being amended to establish in rule that those who are not entitled to no-cost Part A Medicare coverage and, either ineligible for QMB-BAS (which would pay the Part A premium), or do not have a service payment large enough to allow the full premium amount as a deduction, are not required to pursue it. It also establishes in rule that Tri-Care coverage must be pursued.

OAR 461-135-0730 about specific requirements for QMB, SMB, and SMF is being amended to align Oregon policy with federal policy and that of other states by making SMF (QI-1) unavailable to individuals receiving OSIPM.

OAR 461-135-0780, 461-145-0220, 461-155-0250, 461-155-0270, 461-155-0300, 461-160-0580, and 461-160-0620 are being amended to reflect the annual federal cost of living adjustments that happen every January. These amendments keep Oregon in line with current federal standards for Department Medicaid programs and changes in the cost of living.

OAR 461-135-0820 about OSIPM eligibility for widows and widowers is being amended to include clarification from CMS regarding entitlement for Medicare Part A and the requirement to stay under the income and resource limits for OSIPM in the absence of Title II benefits. (See SI 01715.015 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0501715015.)

OAR 461-140-0296 about the length of disqualification due to a disqualifying asset transfer (transfer of an asset for less than its fair market value to become eligible for program benefits) in the Oregon Supplemental Income Program (OSIP) and Oregon Supplemental Income Program Medical (OSIPM) programs is being amended to update the amount used to calculate the number of months of ineligibility due to a disqualifying transfer of assets. This amount is calculated by using the average monthly cost to a private patient of nursing facility services in Oregon. This change was adopted by temporary rule on October 1, 2016.

OAR 461-145-0005 is being amended to state that in the OSIP, OSIPM, and QMB programs, all payments made under the Agent Orange Act of 1991 or from funds established pursuant to Agent Orange product liability litigation are excluded, consistent with federal guidance. (See SI 00830.730 at https://secure.ssa.gov/poms.nsf/lnx/0500830730.)

OAR 461-145-0035 is being adopted to state that Black Lung benefits paid to miners or their survivors under the Federal Mine

Safety and Health Act are counted as unearned income in the OSIP, OSIPM, and QMB programs, consistent with federal guidance. (See SI 00830.215 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830215.)

OAR 461-145-0140 about the Earned Income (EITC) and Making Work Pay (MWP) tax credits is being amended to remove reference to the MWP tax credit. The MWP tax credit ended with the 2011 tax year and therefore the Department no longer needs a rule to state how those credits are treated when determining financial eligibility. (See SI 01130.676 at https://secure.ssa.gov/poms.nsf/lnx/0501130676.)

OAR 461-145-0184 about how the Department treats payments from the Filipino Veterans Equity Compensation Fund when determining financial eligibility is being repealed. These payments were part of the American Recovery and Reinvestment Act (ARRA) of 2009 and the deadline to apply was February 16, 2010. (See Veterans Administration FAQ on WWII Filipino Veterans Equity Compensation (FVEC) Fund at http://www.va.gov/centerforminority veterans/docs/cmvdata/fvecfaqjul10.pdf.)

OAR 461-145-0417 is being adopted to state that Railroad Retirement payments made by the Railroad Retirement Board are counted as unearned income in the OSIP, OSIPM, and QMB programs, consistent with federal guidance. (See SI 00830.225 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830225.)

OAR 461-145-0550 about how unemployment compensation benefits are treated when determining financial eligibility is being amended to remove reference to the supplemental payment authorized by the ARRA. Taxpayers are no longer eligible to receive these payments and therefore the Department no longer needs a rule to state how those credits are treated when determining financial eligibility.

OAR 461-145-0930 about the determination of countable self-employment income is being amended to add consistency with language in OAR 461-145-0120 by adding mileage reimbursements to what is included in countable income.

OAR 461-150-0050 about prospective eligibility and budgeting in the OSIP, OSIPM, and QMB programs is being amended to state that all income is counted in the month received, not excluded if received prior to application. (See SI 00810.010 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810010 and SI 00810.030 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810030.)

OAR 461-180-0050 is being amended to delete an outdated reference to retrospective eligibility and budgeting.

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

461-120-0345

Clients Required to Obtain Health Care Coverage and Cash Medical Support; OSIPM

This rule explains the obligation of clients to obtain health care coverage and cash medical support for members 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) receiving Medicaid through OHA or DHS 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. In the OSIPM program, the applicant is not required to enroll in Medicare Part A coverage if all of the following are true:

(a) The applicant will incur a cost for the coverage.

(b) The applicant is otherwise ineligible for QMB-BAS.

(c) The applicant does not have a service liability in excess of the Part A premium.

(3) Each adult client must make a good faith effort to obtain available coverage under Tri-Care.

(4) 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.

(5) An individual who fails to meet an applicable requirement in sections (1), (2), (3), or (4) of this rule is ineligible.

(6) 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.

(7) 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; SSP 31-2016, f. & cert. ef. 9-1-16; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-135-0730

Specific Requirements; QMB, SMB, SMF

(1) The following requirements apply to QMB-BAS:

(a) To qualify for QMB-BAS, an individual must be receiving Medicare hospital insurance under Part A. This includes an individual who must pay a monthly premium to receive coverage.

(b) A client who qualifies for QMB-BAS is not eligible to receive the full range of the Department's medical services. QMB-BAS benefits are limited to payments toward Medicare cost-sharing expenses. These expenses are:

(A) Medicare Part A and Part B premiums; and

(B) Medicare Part A and Part B deductibles and coinsurance up to the Department's fee schedule.

(2) The following requirements apply to QMB DW:

(a) To qualify for the QMB-DW program, an individual must be eligible for Part A of Medicare as a qualified worker with a disability under Section 1818A of the Social Security Act (42 USC 1395i-2a). This is an individual under age 65 who has lost eligibility for Social Security disability benefits because the individual has become substantially gainfully employed, but can continue to receive Part A of Medicare by paying a premium.

(b) A QMB-DW client is eligible only for payment of premiums for Part A of Medicare. If the client is eligible for any other medical assistance program the client is not eligible for QMB-DW.

(3) The following requirements apply to QMB SMB:

(a) To qualify for QMB SMB, an individual must be receiving Medicare hospital insurance under Part A. This includes an individual who must pay a monthly premium to receive coverage.

(b) A client who qualifies for QMB SMB is not eligible to receive the full range of the Department's medical services. QMB SMB benefits are limited to payment of Medicare Part B premiums.

(4) The following requirements apply to QMB-SMF:

(a) To qualify for QMB-SMF, an individual must be receiving Medicare hospital insurance under Part A. This includes an individual who must pay a monthly premium to receive coverage.

(b) A client who is otherwise eligible for another Medicaid program offered by the Department or the Oregon Health Authority is not eligible for QMB-SMF.

(c) A client who qualifies for QMB-SMF is not eligible to receive the full range of the Department's medical services. QMB-SMF benefits are limited to payment for Medicare Part B premiums.

(d) The QMB-SMF program is subject to an enrollment cap based on the federal allocation. If the enrollment in this program exceeds the federal allocation, the program may be closed.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
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 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 19-2002(Temp), f. 12-10-02, cert. ef. 1-1-03 thru 5-31-03; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 8-2004, f. & cert. ef. 4-1-04; SSP 9-2004(Temp), f. & cert. ef. 4-1-04 thru 6-30-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 3-2006(Temp), f. & cert. ef. 2-6-06 thru 6-30-06; 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 15-2008(Temp), f. & cert. ef. 7-1-08 thru 12-28-08; SSP 19-2008(Temp), f. & cert. ef. 8-8-08 thru 12-28-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-135-0780
Eligibility for Pickle Amendment Clients; OSIPM

(1) An individual is eligible for OSIPM under this rule and the so-called Pickle amendment (Pub. L. No. 94 566, § 503, title V, 90 Stat. 2685 (1976)), if the individual meets all other eligibility requirements, and:

(a) Is receiving Social Security Benefits (SSB);

(b) Was eligible for and receiving SSI or state supplements but became ineligible for those payments after April 1977; and

(c) Would be eligible for SSI or state supplement if the SSB COLA increases paid under section 215(i) of the Social Security Act, after the last month the individual was both eligible for and received SSI or a supplement and was entitled to SSB, were deducted from current SSB.

(2) The SSB amount received by the individual when the individual became ineligible for SSI or OSIP is used as the individual's countable (see OAR 461-001-0000) Social Security income, for the purposes of the Pickle Amendment. If the amount cannot be determined using the information provided by the SSA, it is calculated in accordance with sections (3) and (5) of this rule.

(3) Determine the month in which the individual was entitled to Social Security and received SSI in the same month. Use the table in section (5) of this rule to find the percentage that applies to that month. Multiply the present amount of the individual's Social Security benefits by the applicable percentage. This amount, rounded down to the next lower whole dollar, is the individual's countable Social Security for purposes of this rule and the Pickle Amendment.

(4) Add the amount determined in accordance with section (2) or (3) of this rule to any other countable unearned income plus adjusted earned income of the individual, and if the total is less than the full SSI income standard for a single individual plus the $20 unearned income deduction (OAR 461-160-0550), the individual is eligible for OSIPM for purposes of this rule and the Pickle amendment.

(a) For spouses in the same financial group (see OAR 461-110-0530), determine the spouse's SSB amount in the year the individual stopped receiving SSI or perform the above calculation for the spouse's Social Security benefit using the same multiplier, regardless of whether or not the spouse (see OAR 461-001-0000) received SSI, combine the results and add the subtotal to all other countable unearned and adjusted earned income.

(b) If the total is less than the full SSI standard for a couple plus the $20 unearned income deduction (OAR 461-160-0550), the couple is eligible for OSIPM for purposes of this rule and the Pickle amendment. All other financial and non-financial eligibility criteria must be met.

(5) The following guide contains the calculations used to determine the SSB for prior years (use this table only if you cannot determine the prior year's amount using information provided by SSA): [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.404
Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.404, 411.704
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 30, f. 12-31-90, cert. ef. 1-1-91; AFS 25-1991, f. 12-30-91, cert. ef. 1-1-92; AFS 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; SSP 14-2003(Temp), f. & cert. ef. 6-18-03 thru 9-30-03; 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 4-2005, f. & cert. ef. 4-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 17-2008, f. & cert. ef. 7-1-08; 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 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 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 5-2016, f. & cert. ef. 2-3-16; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-135-0820
Eligibility for Widows and Widowers; OSIPM

A widow or widower receiving Title II benefits from the Social Security Administration claim of a deceased spouse or deceased former spouse is eligible for OSIPM if the individual meets all of the following requirements:

(1) Is not entitled to premium-free Medicare Part A.

(2) Received SSI the month before their Title II payments began.

(3) Would continue to be eligible for SSI benefits in the absence of their Title II benefits.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 12-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

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 and prior to October 1, 2016–$7,663.

(i) If the initial month is on or after October 1, 2016-–$8,425.

(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)(i) 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)(i) 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)(i) 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)(i) 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)(i) 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)(i) 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; SSP 31-2016, f. & cert. ef. 9-1-16; SSP 36-2016(Temp), f. 9-30-16, cert. ef. 10-1-16 thru 3-29-17; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-145-0005
Agent Orange Disability Benefits

(1) For all programs except OSIP, OSIPM, and QMB:

(a) Benefits from the Agent Orange Settlement Fund made by Aetna Life and Casualty for settling Agent Orange disability claims are excluded.

(b) 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.

(2) For OSIP, OSIPM, and QMB, all payments made under the Agent Oregon Act of 1991 or from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the Agent Orange product liability litigation are excluded.

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; SSP 31-2016, f. & cert. ef. 9-1-16; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-145-0035
Black Lung Benefits; OSIP, OSIPM, and QMB

Black Lung Benefits paid to miners or their survivors under the provisions of the Federal Mine Safety and Health Act 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.: SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-145-0140
Earned Income Tax Credit (EITC)

There are federal and state earned income tax credit (EITC) programs for low-income families.

(1) An EITC may be received in one of two ways:

(a) As one annual payment received at the time of the normal income tax returns.

(b) As an advance in the employee's paycheck.

(2) The EITC is excluded from assets (see OAR 461-001-0000).

Stat. Auth.: ORS 411.060, 411.404, 411.706, 411.816, 412.049, 414.231
Stats. Implemented: ORS 411.060, 411.083, 411.404, 411.706, 411.816, 412.049, 414.231
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 6-1991(Temp), f. & cert. ef. 2-8-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; 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 10-2002, f. & cert. ef. 7-1-02; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 11-2010(Temp), f. & cert. ef. 4-22-10 thru 10-19-10; 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 17-2011, f. & cert. ef. 7-1-11; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

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 $560,000 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 $560,000 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; SSP 31-2016, f. & cert. ef. 9-1-16; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-145-0417

Railroad Retirement Payments; OSIP, OSIPM, and QMB

Railroad Retirement payments made by the Railroad Retirement Board 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.: SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-145-0550

Unemployment Compensation Benefit

In all programs covered by Chapter 461 of the Oregon Administrative Rules, unemployment compensation benefits are treated as follows:

(1) Retroactive payments are counted as periodic or lump-sum income (see OAR 461-140-0110 and 461-140-0120).

(2) Disaster Unemployment Assistance is treated as provided in OAR 461-145-0100.

(3) All payments not covered under sections (1) and (2) of this rule are counted as unearned income.

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, 411.070, 411.816, 412.014 & 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 1-1991(Temp), f. & cert. ef. 1-2-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 9-1997, f. & cert. ef. 7-1-97; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 3-2009(Temp), f. & cert. ef. 3-3-09 thru 8-30-09; SSP 24-2009, f. & cert. ef. 8-31-09; SSP 35-2009(Temp), f. & cert. ef. 11-24-09 thru 5-23-10; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-145-0930

Self-Employment; Determination of Countable Income

This rule explains how different programs exclude and deduct costs from self-employment gross sales and receipts.

(1) The Department initially determines gross sales and receipts, including mileage reimbursements, minus any returns and allowances (before excluding or deducting any costs).

(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; SSP 31-2016, f. & cert. ef. 9-1-16; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

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.

(b) 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; SSP 31-2016, f. & cert. ef. 9-1-16; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-155-0250

Income and Payment Standard; OSIPM

(1) An individual who is assumed eligible per OAR 461-135-0010 is presumed to meet the income limits for the OSIPM program.

(2) An individual in a nonstandard living arrangement (see OAR 461-001-0000) meeting the requirements of OAR 461-135-0750, who is not assumed eligible and does not meet the income standards set out in section (4) of this rule, must have countable (see OAR 461-001-0000) income that is equal to or less than 300 percent of the full SSI standard for a single individual (except OSIPM-EPD) or have established a qualifying trust as specified in OAR 461-145-0540(10)(c).

(3) The OSIPM (except OSIPM-EPD) adjusted income standard takes into consideration the need for shelter (housing and utilities), food, and

other items. The standard is itemized as follows: [Table not included. See ED. NOTE.]

(4) An individual, other than one identified in section (1), (2), or (6) of this rule, must have adjusted income below the standard in this section. The Department determines the adjusted number in the household under OAR 461-155-0020. [Table not included. See ED. NOTE.]

(5) In the OSIPM (except OSIPM-EPD) program, an individual in a nursing facility or an ICF-MR is allowed the following amounts for clothing and personal incidentals:

(a) For an individual who receives a VA pension based on unreimbursed medical expenses (UME), $90 is allowed.

(b) For all other individuals, $60.18 is allowed.

(c) For an individual identified in subsection (b) of this section with countable income (including any SSI) that is less than $60.18, the payment standard is equal to the difference between the individual's countable income (including any SSI) and $60.18. For the purposes of this subsection, countable income includes income that would otherwise be countable for an individual who is assumed eligible under OAR 461-135-0010.

(6) In the OSIPM-EPD program, the adjusted earned income limit is 250 percent of the federal poverty level for a family of one.

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

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.704 & 411.706

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.704 & 411.706

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 16-1990, f. 6-29-90, cert. ef. 7-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 25-1991, f. 12-30-91, cert. ef. 1-1-92; AFS 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 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 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; 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 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 10-2003(Temp) f. & cert. ef. 5-1-03 thru 9-30-03; SSP 26-2003, f. & cert. ef. 10-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; 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 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 4-2006, f. & cert. ef. 3-1-06; SSP 6-2006, f. 3-31-06, cert. ef. 4-1-06; 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 2-2007(Temp), f.& cert. ef. 3-1-07 thru 3-31-07; Suspended by SSP 3-2007(Temp), f. & cert. ef. 3-9-07 thru 6-30-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; Suspended by SSP 5-2007(Temp), f. 3-30-07, cert. ef. 4-1-07 thru 6-30-07; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 6-2008(Temp), f. 2-29-08, cert. ef. 3-1-08 thru 8-28-08; 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 2-2009(Temp), f. 2-27-09, cert. ef. 3-1-09 thru 8-28-09; SSP 13-2009, f. & cert. ef. 7-1-09; 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 5-2012(Temp), f. & cert. ef 2-1-12 thru 7-30-12; SSP 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 39-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-30-13; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; 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 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-155-0270

Room and Board Standard; OSIPM

For an OSIPM program client in a community based care (see OAR 461-001-0000) facility, the room and board standard is $571.00. A client residing in a community based care facility must pay room and board.

Stat. Auth.: ORS 411.060, 411.070, 411.704 & 411.706

Stats. Implemented: ORS 411.060, 411.070, 411.704 & 411.706

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 13-2000, f. & cert. ef. 5-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 39-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-30-13; SSP 1-2013(Temp), f. & cert. ef. 1-8-13 thru 6-30-13; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-155-0300

Shelter-in-Kind Standard

In the OSIP, OSIPM, and QMB programs, the Shelter-in-Kind Standard is:

(1) For a single individual:

(a) Living alone, $451 for total shelter or $271 for housing costs only.

(b) Living with others, $209 for total shelter or $125 for housing costs only.

(2) For a couple:

(a) Living alone, $559 for total shelter or $335 for housing costs only.

(b) Living with others, $207 for total shelter or $124 for housing costs only.

Stat. Auth.: ORS 411.060 & 411.070

Stats. Implemented: ORS 411.060 & 411.070

Hist.: 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 12-1991(Temp), f. & cert. ef. 7-1-91; AFS 16-1991, f. 8-27-91, cert. ef. 9-1-91; AFS 25-1991, f. & cert. ef. 1-1-92; AFS 1-1993, f. & cert. ef. 2-1-93; 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 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 40-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 11-1999, f. & cert. ef. 10-1-99; AFS 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; 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 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-160-0580

Excluded Resource; Community Spouse Provision (OSIPM except OSIPM-EPD)

In the OSIPM (except OSIPM-EPD) program:

(1) This rule applies to an institutionalized spouse (see OAR 461-001-0030) who has applied for benefits because the individual is in or will be in a continuous period of care (see OAR 461-001-0030).

(2) Whether a legally married (see OAR 461-001-0000) couple lives together or not, the determination of whether the value of the couple's resources exceeds the eligibility limit for the institutionalized spouse for the OSIPM program is made as follows:

(a) The first step is the determination of what the couple's combined countable (see OAR 461-001-0000) resources were at the beginning of the most recent continuous period of care. (The beginning of the continuous period of care is the first month of that continuous period.)

(A) Division 461-140 and 461-145 rules applicable to OSIPM describe which of the couple's resources are countable resources, and are applicable to determine whether a community spouse's resources are countable, even if the rule only applies to OSIPM clients.

(B) The countable resources of both spouses are combined.

(C) At this point in the computation, the couple's combined countable resources are considered available equally to both spouses.

(b) The second step is the calculation of one half of what the couple's combined countable resources were at the beginning of the continuous period of care. The community spouse's half of the couple's combined resources is treated as a constant amount when determining eligibility.

(c) The third step is the determination of the community spouse's resource allowance. The community spouse's resource allowance is the largest of the four following amounts:

(A) The community spouse's half of what the couple's combined countable resources were at the beginning of the continuous period of care, but not more than $120,900.

(B) $24,180 (the state community-spouse resource allowance).

(C) A court-ordered community spouse resource allowance. In this paragraph and paragraph (2)(f)(C) of this rule, the term "court-ordered community spouse resource allowance" means a "court-ordered community spouse resource allowance" that, in relation to the income generated, would raise the community spouse's income to a court-approved monthly maintenance needs allowance. In cases where the client became an institutionalized spouse on or after February 8, 2006, this resource allowance must use all of the client's available income and the community spouse's income to meet the community spouse's monthly maintenance needs allowance before any resources are used to generate interest income to meet the allowance.

(D) After considering the income of the community spouse (see OAR 461-001-0030) and the income available from the institutionalized spouse, an amount which, if invested, would raise the community spouse's income to the monthly maintenance needs allowance. The amount described in this paragraph is the amount required to purchase a single premium immediate annuity to make up the shortfall; and the amount described in this paragraph is considered only if the amount described in subparagraph (i) of this paragraph is larger than the amount described in subparagraph (ii); it is the difference between the following:

(i) The monthly income allowance computed in accordance with OAR 461-160-0620.

(ii) The difference between:

(I) The sum of gross countable income of the community spouse and the institutionalized spouse; and

(II) The applicable need standard under OAR 461-160-0620(3)(c).

(d) The fourth step is the determination of what the couple's current combined countable resources are when a resource assessment is requested or the institutionalized spouse applies for OSIPM. The procedure in subsection (2)(a) (first step) of this rule is used.

(e) The fifth step is the subtraction of the community spouse's resource allowance from the couple's current combined countable resources. The resources remaining are considered available to the institutionalized spouse.

(f) The sixth step is a comparison of the value of the remaining resources to the OSIPM resource standard for one person (under OAR 461-160-0015). If the value of the remaining resources is at or below the standard, the institutionalized spouse meets this eligibility requirement. If the value of the remaining resources is above the standard, the institutionalized spouse cannot be eligible until the value of the couple's combined countable resources is reduced to the largest of the four following amounts:

(A) The community spouse's half of what the couple's combined countable resources were at the beginning of the continuous period of care (but not more than $120,900) plus the OSIPM resource standard for one person.

(B) $24,180 (the state community-spouse resource allowance), plus the OSIPM resource standard for one person.

(C) A "court-ordered community spouse resource allowance" plus the OSIPM resource standard for one person. (See paragraph (2)(c)(C) of this rule for a description of the "court-ordered community spouse resource allowance".)

(D) The OSIPM resource standard for one person plus the amount described in the remainder of this paragraph. After considering the income of the community spouse and the income available from the institutionalized spouse, add an amount which, if invested, would raise the community spouse's income to the monthly maintenance needs allowance. This amount is the amount required to purchase a single premium immediate annuity to make up the shortfall. Add this amount only if the amount described in subparagraph (i) of this paragraph is larger than the amount described in subparagraph (ii); it is the difference between the following:

(i) The monthly income allowance computed in accordance with OAR 461-160-0620.

(ii) The difference between:

(I) The sum of gross countable income of the community spouse and the institutionalized spouse; and

(II) The applicable need standard under OAR 461-160-0620(3)(c).

(3) Once eligibility has been established, resources equal to the community spouse's resource allowance (under subsection (2)(c) of this rule) must be transferred to the community spouse if those resources are not already in that spouse's name. The institutionalized spouse must indicate his or her intent to transfer the resources and must complete the transfer to the community spouse within 90 days. This period may be extended for good cause. These resources are excluded during this period. After this period, resources owned by the institutionalized spouse but not transferred out of that spouse's name will be countable and used to determine ongoing eligibility.

(4) The provisions of paragraph (2)(c)(C) of this rule requiring income to be considered first may be waived if the Department determines that the resulting community resource allowance would create an undue hardship on the spouse (see OAR 461-001-0000) of the client.

Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.404 & 411.706
Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.404 & 411.706
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 16-1990, f. 6-29-90, cert. ef. 7-1-90; AFS 3-1991(Temp), f. & cert. ef. 1-17-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 5-1993, f. & cert. ef. 4-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 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 9-1999, f. & cert. ef. 7-1-99; AFS 11-1999, f. & cert. ef. 10-1-99; AFS 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; 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; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 5-2006(Temp), f. & cert. ef. 3-6-06 thru 8-31-06; 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 4-2007, f. 3-30-07, cert. ef. 4-1-07; 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 38-2009, f. 12-31-09, cert. ef. 1-1-10; 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 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

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 $60.18 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 $3,022.50 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; SSP 31-2016, f. & cert. ef. 9-1-16; SSP 44-2016, f. 12-7-16, cert. ef. 1-1-17

461-180-0050
Effective Dates; Suspending or Closing Benefits and JOBS Support Service Payments

(1) This rule explains the effective date for closing or suspending benefits for the entire benefit group (see OAR 461-110-0750) and the effective date for ending JOBS support service payments.

(2) In all programs except the ERDC program, when the only individual in a benefit group dies, the effective date of the closure is:

(a) In the REF, SNAP, and TANF programs, the last day of the month in which the death occurred.

(b) In all other programs, the date of the death.

(3) For all closures and suspensions not covered by section (2) of this rule, the effective date is determined as follows:

(a) When prospective eligibility is used, the effective date for closing or suspending benefits is the last day of the month in which the notice period ends.

(b) For a pregnant female receiving benefits of the OSIPM program, the effective date for closing benefits is no earlier than the last day of the calendar month in which the 60th day after the last day of pregnancy falls, except at the client's request.

(c) For a client who is receiving medical assistance and becomes incarcerated with an expected stay of a year or less, the effective date for suspending medical benefits is the effective date on the decision notice (see OAR 461-001-0000).

(d) The effective date for ending support service payments authorized under OAR 461-190-0211 is the earlier of the following:

(A) The date the related JOBS activity is scheduled to end.

(B) The date the client no longer meets the requirements of OAR 461-190-0211.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 414.231, 414.826
Stats. Implemented: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 414.231, 414.826
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 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 36-1996, f. 10-31-96, cert. ef. 11-1-96; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 18-2004, f. & cert. ef 7-12-04; 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 5-2010, f. & cert. ef. 4-1-10; 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 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 44-2016, f. 12-7-16, cert. ef. 1-1-17

Department of Justice
Chapter 137

Rule Caption: Amends rules regarding tobacco product manufacturers and adopts Model Escrow Agreement.
Adm. Order No.: DOJ 13-2016
Filed with Sec. of State: 11-17-2016
Certified to be Effective: 11-17-16
Notice Publication Date: 10-1-2016
Rules Adopted: 137-105-0025
Rules Amended: 137-105-0001, 137-105-0010, 137-105-0020, 137-105-0030
Subject: OAR 137-105-0001 is being amended to correct a clerical error.

OAR 137-105-0010(k) is being amended to correct clerical errors.

OAR 137-105-0020 is being amended to remove references to annual escrow deposits and clarify that all tobacco product manufacturers who are required to make escrow deposits are required to do so on a quarterly basis.

OAR 137-105-0025 is being adopted to define the form and content of the Attorney General's model escrow agreement.

OAR 137-105-0030 is being amended to clarify the requirements for distributor reports.
Rules Coordinator: Carol Riches—(503) 378-5987

137-105-0001
Definitions

The following definitions shall apply to all Oregon Administrative Rules contained in division 105 unless the context requires otherwise:

(1) "Brand Family" has the meaning given that term in ORS 180.405.

(2) "Cigarette" has the meaning given that term in ORS 323.800.

(3) "Certification" means the information required to be provided to the Attorney General under ORS 180.410 and 180.415.

(4) "Directory" means the listing of tobacco product manufacturers that have provided current and accurate certifications pursuant to the provisions of ORS 180.425.

(5) "Distributor" has the meaning given that term in ORS 180.405(3).

(6) "NPM Distributor report" means the information required to be provided to the Attorney General under ORS 180.435(1).

(7) "Escrow deposit" means deposits required to be made into a qualified escrow fund pursuant to ORS 323.806(2)(a).

(8) "Master Settlement Agreement" has the meaning given that term in ORS 323.800.

(9) "Participating manufacturer" has the meaning given that term in ORS 180.405.

(10) "Qualified escrow fund" has the meaning given that term in ORS 323.800.

(11) "Tobacco product manufacturer" has the meaning given that term in ORS 323.800.

(12) "Units Sold" has the meaning given that term in ORS 323.800.

Stat. Auth.: ORS 180.445
Stats. Implemented:
Hist.: DOJ 9-2004, f. & cert. ef. 5-25-04; DOJ 13-2016, f. & cert. ef. 11-17-16

137-105-0010
Tobacco Product Manufacturers Directory

(1) In exercising the discretion granted by ORS 180.425(2), the Attorney General will consider the following:

(a) Whether the entity tendering a certification is a tobacco product manufacturer;

(b) Timeliness of the certification made by the tobacco product manufacturer;

(c) Completeness, or lack thereof, of the certification made by the tobacco product manufacturer;

(d) Whether the tobacco product manufacturer has provided all requested documents supporting its certification;

(e) Whether the certification is based on misrepresentation, false information, nondisclosure or concealment of facts;

(f) Whether the tobacco product manufacturer is in full compliance with all provisions of Local, State and Federal Law, including but not limited to the provisions of ORS 180.410, 180.415 and 323.800 to 323.806.

(g) Whether the tobacco product manufacturer, predecessor of the tobacco product manufacturer, or previous manufacturer of the brand is the

subject of an injunction obtained by the State of Oregon for previous failure to comply with the nonparticipating manufacturer statutes;

(h) Whether the tobacco product manufacturer has failed to fully or timely fund a qualified escrow fund approved by the Attorney General;

(i) Whether all final judgments and penalties, including interest, costs and attorney fees thereon, in favor of the State of Oregon, or any political subdivision thereof, for violation of any Oregon statute, administrative rule or other law, including but not limited to violations of ORS 323.800 to 323.806, have been fully satisfied for the name, brand family, or tobacco product manufacturer;

(j) Whether the tobacco product manufacturer has corrected deficiencies in its certification or criteria set forth in this section in a timely and thorough manner;

(k) Whether the tobacco product manufacturer has complied in a timely and thorough manner with any request by the Attorney General pursuant to ORS 180.435 for additional information or documentation or the criteria set forth in this section; and

(l) Any other facts or circumstances the Attorney General determines are relevant.

(2) In a manner provided in subsection (5) of this rule, the Attorney General shall remove a tobacco product manufacturer or brand family from the directory if the Attorney General determines that the tobacco product manufacturer or the brand family no longer meets the requirements of ORS 180.410 and 180.415.

(3) In the manner provided in subsection (5) of this rule, the Attorney General shall reject the application of a tobacco product manufacturer or brand family to be listed in the directory if the Attorney General determines that the tobacco product manufacturer or the brand family does not meet the requirements of ORS 180.410 and 180.415.

(4) The Attorney General shall promptly notify a tobacco product manufacturer in writing (via email or regular mail) if the manufacturer has met the requirements of ORS 180.410 and 180.415 and will be included in the directory. The notice shall include each brand family that the Attorney General determines will be included in the directory.

(5) If, on or after the effective date of these rules, the Attorney General intends to deny a tobacco product manufacturer or brand family a place in the directory, to remove a manufacturer or brand family from the directory, or to exclude an entity because the entity is not a tobacco product manufacturer, the Attorney General shall mail a written Notice of Intended Action to the manufacturer or entity. The Notice of Intended Action shall specify:

(a) The factual and legal basis upon which the Attorney General's intended action rests;

(b) The actions that the tobacco product manufacturer or entity must complete to cure the factual or legal deficiencies upon which the intended action is based; and,

(c) The date upon which attempts to cure the deficiencies must be completed and documentation of completion must be submitted to the Attorney General. In no event shall the Attorney General allow the tobacco product manufacturer or entity less than 15 days within which to cure the deficiencies upon which the Attorney General's intended action is based.

(6) On or before the deadline set in the Notice of Intended Action, the tobacco product manufacturer or entity shall provide documentation to the Attorney General detailing the actions, if any, that the tobacco product manufacturer or entity has taken to cure the deficiencies identified by the Attorney General in the Notice of Intended Action.

(7) Within 45 days of the date on which a certification that is the subject of a Notice of Intent is received, the Attorney General shall determine whether the deficiencies have been cured.

(a) If the deficiencies have been cured to the satisfaction of the Attorney General, the Attorney General shall promptly notify a tobacco product manufacturer in writing (via email or regular mail) that the manufacturer or brand family will be included in the directory.

(b) If any of the deficiencies have not been cured to the satisfaction of the Attorney General, the Attorney General shall promptly issue an order in Other than Contested Case denying a manufacturer, brand family, or entity a place in the directory.

(8) A tobacco product manufacturer or entity that has complied with subsection (6) of this rule and is aggrieved by an Order denying the manufacturer or brand family a place in the directory may file a petition for judicial review of the Attorney General's order as provided in ORS 183.484.

(9) The Attorney General may, for any reason and at the Attorney General's discretion, extend any period allowed by these rules.

Stat. Auth.: ORS 180.445
Stats. Implemented:
Hist.: DOJ 9-2004, f. & cert. ef. 5-25-04; DOJ 13-2016, f. & cert. ef. 11-17-16

137-105-0020
Escrow Deposits

(1) Each tobacco product manufacturer shall make the escrow deposits required by ORS 323.806 in quarterly payments for each of the following periods of the year: January 1 through March 31; April 1 through June 30; July 1 through September 30; and October 1 through December 31. The quarterly escrow payments shall be made no later than 15 days after the end of each quarter.

(2) The calculation for the amount of the escrow deposit required for deposit into the qualified escrow fund for any given quarter will be based on the number of units sold by the tobacco product manufacturer during the corresponding quarter, as adjusted for inflation pursuant to ORS 323.806(2)(a)(A)-(E).

(3) Nonparticipating tobacco manufacturers must provide the Attorney General with official notification of the quarterly escrow deposit by filing an Oregon Quarterly Escrow Compliance Certificate and Affidavit with the Office of the Attorney General no later than the 10th day after the deadline for which an escrow deposit is required.

(4) Nonparticipating tobacco manufacturers must provide the Attorney General with official notification of the annual escrow deposit by filing an Oregon Annual Escrow Compliance Certificate and Affidavit with the Office of the Attorney General no later than the 30th day of April following the reporting year.

(5) The Attorney General may at any time, upon written request, require a tobacco product manufacturer to produce all invoices and documentation of sales and other information relied upon in filing a Quarterly or Annual Escrow Compliance Certificate.

Stat. Auth.: ORS 180.445
Stats. Implemented:
Hist.: DOJ 9-2004, f. & cert. ef. 5-25-04; DOJ 13-2016, f. & cert. ef. 11-17-16

137-105-0025
Model Escrow Agreement

(1) The model escrow agreement set forth in OAR 137-105-0025(2) is provided for use by tobacco product manufacturers who are required to execute a qualified escrow agreement. A tobacco product manufacturer that executes the model escrow agreement set forth in OAR 137-105-0025(2) is deemed to have satisfied the requirement of ORS 180.415(2)(b) that it use a form of escrow agreement that has been reviewed and approved by the Attorney General.

(2) [Model Escrow Agreement] [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 180.415(2)(b)
Stats. Implemented: ORS 180-415(2)(b)
Hist.: DOJ 7-2016(Temp), f. & cert. ef. 5-23-16 thru 11-18-16; DOJ 13-2016, f. & cert. ef. 11-17-16

137-105-0030
Distributor Reports

(1) No later than the 15th day following the end of each month, each distributor shall report to the Attorney General the total number of cigarettes, littler cigars, and ounces of roll your own tobacco sold on which the distributor affixed tax stamps or otherwise paid the tax due during the reporting month.

(2) Reports under section 1 of this rule should not include cigarettes, little cigars, or roll your own tobacco that were tax paid at the time the distributor acquired them.

(3) In making the reports required by section 1 of this rule, the distributor shall certify that the information provided is true and accurate.

(4) The Department of Justice shall promulgate a form entitled Brand Specific Report for Cigarettes, Little Cigars, and Roll-Your-Own Product with Oregon Tax Paid for All Manufacturers. Distributors shall use the Brand Specific Report for Cigarettes, Little Cigars, and Roll-Your-Own Product with Oregon Tax Paid for All Manufacturers form for reports required by section 1 of this rule. Brand Specific Report for Cigarettes, Little Cigars, and Roll-Your-Own Product with Oregon Tax Paid for All Manufacturers forms shall be mailed to Department of Justice, Civil Enforcement, 1162 Court Street NE, Salem, Oregon 97301.

Stat. Auth.: ORS 180.445
Stats. Implemented:
Hist.: DOJ 9-2004, f. & cert. ef. 5-25-04; DOJ 13-2016, f. & cert. ef. 11-17-16

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Rule Caption: Adopting rules relating to smokeless tobacco products
Adm. Order No.: DOJ 14-2016
Filed with Sec. of State: 11-17-2016
Certified to be Effective: 11-17-16

Notice Publication Date: 10-1-2016
Rules Adopted: 137-106-0001, 137-106-0010, 137-106-0030, 137-106-0040
Subject: ORS 180.465 to 180.494 gives the Attorney General authority to regulate the sale of smokeless tobacco products.

OAR 137-106-0001 provides definitions for the proposed rules.

OAR 137-106-0010 provides criteria and procedure for the Attorney General to use in developing and maintaining a directory pursuant to ORS 180.477.

OAR 137-106-0030 provides guidance to regulated parties regarding reports required by ORS 180.483.

OAR 137-106-0040 provides guidance regarding the calculation of time periods under the proposed rules.
Rules Coordinator: Carol Riches—(503) 378-5987

137-106-0001
Definitions

The following definitions shall apply to all Oregon Administrative Rules contained in division 106 unless the context requires otherwise:

(1) "Distributor" has the meaning given that term in ORS 180.468.

(2) " Distributor report" means the information required to be provided to the Attorney General under ORS 180.483.

(3) "Nonparticipating manufacturer" has the meaning given that term in ORS 180.468.

(4) "Participating manufacturer" has the meaning given that term in ORS 180.468.

(5) "Smokeless Master Settlement Agreement" has the meaning given that term in ORS 323.810.

(6) "Smokeless Tobacco Products" has the meaning given that term in ORS 323.810.

(7) "Tobacco product manufacturer" has the meaning given that term in ORS 323.810.

Stat. Auth.: ORS 180.477, 180.483
Stats. Implemented: ORS 180.477, 180.483
Hist.: DOJ 14-2016, f. & cert. ef. 11-17-16

137-106-0010
Tobacco Product Manufacturers Directory

(1) In exercising the discretion granted by ORS 180.477(2), the Attorney General will consider the following:

(a) Whether the entity tendering a certification is a tobacco product manufacturer;

(b) Timeliness of the certification made by the tobacco product manufacturer;

(c) Completeness, or lack thereof, of the certification made by the tobacco product manufacturer;

(d) Whether the tobacco product manufacturer has provided all requested documents supporting its certification;

(e) Whether the certification is based on misrepresentation, false information, nondisclosure or concealment of facts;

(f) Whether the tobacco product manufacturer is in full compliance with all provisions of Local, State and Federal Law, including but not limited to the provisions of ORS 180.471, 180.474, and 323.810 to 323.816.

(g) Whether the tobacco product manufacturer, predecessor of the tobacco product manufacturer, or previous manufacturer of the brand is the subject of an injunction obtained by the State of Oregon for previous failure to comply with the nonparticipating manufacturer statutes;

(h) Whether the tobacco product manufacturer has failed to fully or timely fund a qualified escrow fund approved by the Attorney General;

(i) Whether all final judgments and penalties, including interest, costs and attorney fees thereon, in favor of the State of Oregon, or any political subdivision thereof, for violation of any Oregon statute, administrative rule or other law, including but not limited to violations of ORS 323.810 to 323.816, have been fully satisfied for the name, brand family, or tobacco product manufacturer;

(j) Whether the tobacco product manufacturer has corrected deficiencies in its certification or criteria set forth in this section in a timely and thorough manner;

(k) Whether the tobacco product manufacturer has complied in a timely and thorough manner with any request by the Attorney General pursuant to ORS 180.483 for additional information or documentation or the criteria set forth in this section; and

(l) Any other facts or circumstances the Attorney General determines are relevant.

(2) In a manner provided in subsection (5) of this rule, the Attorney General shall remove a tobacco product manufacturer or brand family from the directory if the Attorney General determines that the tobacco product manufacturer or the brand family no longer meets the requirements of ORS 180.471 and 180.474.

(3) In the manner provided in subsection (5) of this rule, the Attorney General shall reject the application of a tobacco product manufacturer or brand family to be listed in the directory if the Attorney General determines that the tobacco product manufacturer or the brand family does not meet the requirements of ORS 180.471 and 180.474.

(4) The Attorney General shall promptly notify a tobacco product manufacturer in writing (via email or regular mail) if the manufacturer has met the requirements of ORS 180.471 and 180.474 and will be included in the directory. The notice shall include each brand family that the Attorney General determines will be included in the directory.

(5) If, on or after the effective date of these rules, the Attorney General intends to deny a tobacco product manufacturer or brand family a place in the directory, to remove a manufacturer or brand family from the directory, or to exclude an entity because the entity is not a tobacco product manufacturer, the Attorney General shall mail a written Notice of Intended Action to the manufacturer or entity. The Notice of Intended Action shall specify:

(a) The factual and legal basis upon which the Attorney General's intended action rests;

(b) The actions that the tobacco product manufacturer or entity must complete to cure the factual or legal deficiencies upon which the intended action is based; and,

(c) The date upon which attempts to cure the deficiencies must be completed and documentation of completion must be submitted to the Attorney General. In no event shall the Attorney General allow the tobacco product manufacturer or entity less than 15 days within which to cure the deficiencies upon which the Attorney General's intended action is based.

(6) On or before the deadline set in the Notice of Intended Action, the tobacco product manufacturer or entity shall provide documentation to the Attorney General detailing the actions, if any, that the tobacco product manufacturer or entity has taken to cure the deficiencies identified by the Attorney General in the Notice of Intended Action.

(7) Within 45 days of the date on which a certification that is the subject of a Notice of Intent is received, the Attorney General shall determine whether the deficiencies have been cured.

(a) If the deficiencies have been cured to the satisfaction of the Attorney General, the attorney General shall promptly notify a tobacco product manufacturer in writing (via email or regular mail) that the manufacturer or brand name family will be included in the directory.

(b) If any of the deficiencies have not been cured to the satisfaction of the Attorney General, the Attorney General shall promptly issue an order in Other than Contested Case denying a manufacturer, brand name family, or entity a place in the directory.

(8) A tobacco product manufacturer or entity that has complied with subsection (6) of this rule and is aggrieved by an Order denying the manufacturer or brand name family a place in the directory may file a petition for judicial review of the Attorney General's order as provided in ORS 183.484.

(9) The Attorney General may, for any reason and at the Attorney General's discretion, extend any period allowed by these rules.

Stat. Auth.: ORS 180.477, 180.483
Stats. Implemented: ORS 180.477, 180.483
Hist.: DOJ 14-2016, f. & cert. ef. 11-17-16

137-106-0030
Distributor Reports

(1) No later than the 20th day following the end of each calendar quarter, each distributor shall report to the Attorney General the total number of smokeless tobacco products sold on which the distributor paid the tax due during the reporting month.

(2) Reports under section 1 of this rule should not include smokeless tobacco products that were tax paid at the time the distributor acquired them.

(3) In making the reports required by section 1 of this rule, the distributor shall certify that the information provided is true and accurate.

(4) The Department of Justice shall promulgate a form entitled Quarterly Brand Specific Report for Smokeless Tobacco Products with Oregon Tax Paid for All Manufacturers. Distributors shall use the Quarterly Brand Specific Report for Smokeless Tobacco Products with Oregon Tax Paid for All Manufacturers form for reports required by section 1 of this rule. Quarterly Brand Specific Report for Smokeless Tobacco Products

with Oregon Tax Paid for All Manufacturers forms shall be mailed to Department of Justice, Civil Enforcement, 1162 Court Street NE, Salem, Oregon 97301.

Stat. Auth.: ORS 180.477, 180.483
Stats. Implemented: ORS 180.477, 180.483
Hist.: DOJ 14-2016, f. & cert. ef. 11-17-16

137-106-0040
Calculation of Time for Purposes of These Rules

In computing any period of time prescribed or allowed by these rules, the period shall be calculated as provided in Oregon Rule of Civil Procedure 10A.

Stat. Auth.: ORS 180.477, 180.483
Stats. Implemented: ORS 180.477, 180.483
Hist.: DOJ 14-2016, f. & cert. ef. 11-17-16

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Department of State Police
Chapter 257

Rule Caption: Amend rules to clarify when a tow business or employee can be denied from participation
Adm. Order No.: OSP 2-2016(Temp)
Filed with Sec. of State: 11-18-2016
Certified to be Effective: 11-18-16 thru 5-16-17
Notice Publication Date:
Rules Amended: 257-050-0145, 257-050-0050
Subject: OAR 257-050-0145 dictates the conditions under which a tow business owner or employee is disqualified from participation in the OSP non-preference tow program based on felony convictions. The rules currently state that if a tow business, a qualified tow business or an owner or employee is convicted of certain felony offenses, the Department "shall deny, suspend, or revoke a tow business' application or a qualified tow business' letter of appointment..." Under the current rules, if any employee is ineligible based on any described felony convictions, the entire tow business or qualified tow business becomes ineligible to participate in the non-preference tow program. The proposed amendments to the rule will narrow "employee" to "driver," clarify to whom and to what entities the felony conviction prohibitions apply, and will allow a tow business or qualified tow business to remain eligible to participate in the program if it prevents a disqualified driver from engaging in any work that is referred to the business by the Department. The proposed amendments are intended to provide flexibility to allow otherwise-eligible tow businesses and qualified tow businesses to continue participating in the non-preference tow program by segregating ineligible drivers and preventing them from participation in the Department's non-preference tow program. However, with the additional clarifications, the proposed rule amendments maintain the current requirement that a tow business will be ineligible to receive a letter of appointment for participation in the Department's non-preference tow program, or a qualified tow business' existing letter of appointment will be revoked, if the tow business, qualified tow business, a manager of daily operations or a principal of the business is disqualified based on any of the felony convictions specified in OAR 257-050-0145.

The proposed rule amendments will also require that OSP be notified if a qualified tow business, tow business, manager of daily operations, or principal becomes aware that a driver is ineligible because of any disqualifying felony conviction and will clarify that OSP may conduct LEDS checks or check court records to determine the existence of felony convictions.

OAR 257-050-0050 has also been amended to add definitions for new terms that are used in the amendments to OAR 257-050-0145 and for terms that previously were not defined.

The Department intends that these temporary rule amendments will apply to any application for a letter of appointment or any letter of appointment in effect before, on, or after the effective date of these rule amendments.
Rules Coordinator: Shannon Peterson—(503) 934-0183

257-050-0145
Felony Convictions

(1) The Department shall deny a tow business' application for a letter of appointment or revoke a qualified tow business' letter of appointment for any of the following reasons:

(a) A qualified tow business, tow business, manager of daily operations, or principal is convicted of any Oregon felony offense, or any offense in another United States court that is equivalent to an Oregon felony offense, within the preceding fifteen (15) years from the date the application for a letter of appointment is received by the Department. This subsection is subject to the provisions set forth under ORS 166.270(4)(b).

(b) A qualified tow business, tow business, manager of daily operations, or principal is convicted of two or more felony offenses. This subsection applies regardless of the date of the conviction.

(c) A manager of daily operations or principal is convicted of any felony offense, or any offense in another United States court that is the equivalent of an Oregon felony offense, where a weapon was used or threatened to be used in the commission of the crime. This subsection applies regardless of the date of the conviction.

(d) A manager of daily operations or principal is convicted of any sex crimes. This subsection applies regardless of the date of the conviction.

(2) Disqualified drivers.

(a) A driver that has any conviction described in subsection (1) of this administrative rule is disqualified from operating any tow vehicle on behalf of a qualified tow business and shall not participate in the towing of vehicles for a qualified tow business under the Department's non-preference tow program.

(b) A qualified tow business that employs a driver that has any conviction described in subsection (1) of this administrative rule will remain eligible to participate in the Department's non-preference tow program under a letter of appointment. However, the qualified tow business shall not allow a driver that is ineligible under this subsection to participate in the towing of vehicles on behalf of the qualified tow business under any letter of appointment issued by the Department.

(c) Qualified tow businesses, tow businesses, managers of daily operations, and principals who become aware that a driver is disqualified under this subsection shall immediately notify the Department of the driver and the reason for the disqualification.

(3) The Department may, at any time, conduct Oregon LEDS checks of qualified tow businesses, tow businesses, managers of daily operations, principals, and drivers in order to enforce its administrative rules. The Department may also conduct checks of court records in order to determine the existence of felony convictions, dates of convictions, and other disqualifying factors under its administrative rules.

(4) These rules apply to any application for a letter of appointment or any letter of appointment in effect before, on, or after the effective date of these rule amendments.

Stat. Auth.: ORS 181A.350
Stats. Implemented: ORS 181A.350
Hist.: OSP 5-2005, f. & cert. ef. 11-18-05; OSP 1-2006, f. 3-29-06, cert. ef. 3-31-06; OSP 1-2009(Temp), f. & cert. ef. 8-6-09 thru 1-31-10; OSP 2-2009, f. 10-8-09 cert. ef. 1-1-10; OSP 3-2009(Temp), f. 12-18-09, cert. ef. 1-1-10 thru 6-29-10; OSP 3-2010, f. 6-1-10, cert. ef. 6-30-10; OSP 2-2016(Temp), f. & cert. ef. 11-18-16 thru 5-16-17

257-050-0050
Definitions

(1) "Abandoned Auto" or "Abandoned Vehicle" — A vehicle, as defined in ORS 819.110, that has been parked or left standing upon any public way for a period in excess of 24 hours without authorization by statute or local ordinance.

(2) "Another United States court" – The definition contained in ORS 163A.005(1).

(3) "Area Commander" or "Station Commander" — The local commanding officer of an area established by the Oregon State Police.

(4) "Business Records" — Those records maintained by a qualified tow business that relate to the non-preference tows and which include, but are not limited to, tow bills, letters of appointment, and inspection sheets.

(5) "Certified" or "Certification" — The successful completion by an employee of a tow business of a written test administered by a nationally recognized towing affiliated body/organization relating to the level of towing the employee operates.

(6) "Convicted" — An adjudication of guilt upon a verdict or finding entered in a criminal proceeding in a court of competent jurisdiction.

(7) "Denial" — Action taken by the Department in refusing to issue a letter of appointment to a tow business.

(8) "Department" — The Department of State Police, also referred to as "Oregon State Police," and its employees.

(9) "Driver" — Any individual or employee associated with a qualified tow business or tow business and who operates a tow vehicle, regardless of whether the individual is listed in an application for a letter of appointment.

(10) "Employee" — Any person in the service of a tow business under contract of hire, express or implied, oral or written, where the business has the power or right to control and direct the employee in the material details of how the work for the business is to be performed.

(11) "Fencing" — Permanent fencing meeting zoning requirements, with a minimum height of six (6) feet.

(12) "Hazardous Vehicle" — A vehicle, as defined in ORS 819.120, that is disabled, abandoned, parked, or left standing unattended on a road or highway right of way and that is in such a location as to constitute a hazard or obstruction to motor vehicle traffic using the road or highway given that term in OAR 734-020-0147.

(13) "Hearings Officer" — A person appointed by an agency or entity contracted by the Department of State Police to conduct contested case hearings.

(14) "Highway" — Every public way, road, street, thoroughfare and place including bridges, viaducts and other structures within the boundaries of the state open, used or intended for use of the general public for vehicles or vehicular traffic as a matter of right (ORS 801.305).

(15) "Inspector" — A commissioned officer or other appointed representative of the Oregon State Police who has been designated by the Department to examine tow trucks and qualified tow businesses.

(16) "Letter of Appointment" — A letter issued by the Department that authorizes a tow business to tow abandoned or disabled vehicles on a non-preference rotational basis for the Oregon State Police.

(17) "Manager of daily operations" — Any individual who has control or direction of the day-to-day, regulatory, or financial aspect of a tow business or qualified tow business.

(18) "Non-Preference tow rotational List' or "Non-Preference List" — The list of qualified tow businesses maintained at Oregon State Police Headquarters that is used to dispatch the tow trucks on an equitable basis when no choice or preference to a tow business is stated by the vehicle owner, driver, or other person responsible for the vehicle.

(19) "On Road Time" — The time it takes a qualified tow business to have a tow truck started and on the road from the time the dispatcher was called by the Department.

(20) "Patrol Services Division" — The administrative body of the Oregon State Police that is located at General Headquarters in Salem, Oregon.

(21) "Place of Business" — A separate building or physical structure that a qualified tow business occupies, either continuously or at regular times, where the qualified tow business' business books and records are kept and the business of towing vehicles is transacted in each assigned tow zone. Multiple or different qualified tow businesses may operate on a single piece of real property, provided that each qualified tow business maintains individual and separate records, storage facilities, and letters of appointment in order to be placed on the Department's non-preference tow rotational list.

(22) "Principal" — an owner, partner, corporate officer or other person or entity that controls, manages or has a financial interest in, a tow business or qualified tow business.

(23) "Qualified Tow Business" is a tow business with a current letter of appointment issued by the Department.

(24) "Region Commander" or "District Commander" — The commanding officer of the region as established by the Oregon State Police.

(25) "Recovery Vehicle" — A motor vehicle that is:

(a) A commercially available truck chassis equipped with a commercially manufactured tow body or bed, that is rated and issued a serial number by the manufacturer;

(b) Designed and equipped for, and used in, the towing and/or recovery of vehicles;

(c) Capable of towing a vehicle by means of a tow bar, sling or wheel lift; and

(d) Capable of recovering a vehicle by means of a hoist, winch and towline.

(26) "Response Time" — The reasonable driving time it takes a tow truck to respond to the dispatched location once the tow truck is on the road.

(27) "Revocation" and "revoked" — The termination of a letter of appointment or right to apply for a letter of appointment, and the removal from the Oregon State Police's non-preference towing program for a period of not less than 10 years, which becomes effective from the date of the Notice of Revocation from the Oregon State Police.

(28) "Right to apply" — The right of a tow business or its principal(s) to apply for, and the right of a qualified tow business or its principal(s) to re-apply for, a letter of appointment.

(29) "Sex crime" — The crimes listed in ORS 163A.005(5). "Sex crime" includes an equivalent conviction from another United States court, regardless of the degree of the criminal offense.

(30) "Suspension" and "suspend" — The temporary withdrawal of a letter of appointment or right to apply for a letter of appointment, and the removal from the Oregon State Police non-preference towing program for a period of not more than 10 years.

(31) "Tow business" — Any person, enterprise, corporation or partnership that engages in the impounding, transporting, recovery or storage of towed or abandoned vehicles or in the disposal of abandoned vehicles.

(32) "Tow Vehicle" — A motor vehicle that is:

(a) Altered or designed and equipped for, and used in, the business of towing vehicles; and

(b) Used to tow vehicles by means of a crane hoist, tow bar, towline or dolly, or otherwise used to render assistance to other vehicles (ORS 801.530).

(33) "Tow Zone" — The geographical area designated by the area commander for the removal of vehicles.

(34) "Vehicle Storage Area" — The approved yard or enclosed building where a qualified tow business keeps or stores towed vehicles.

Stat. Auth.: ORS 181A.350
Stats. Implemented: ORS 181A.350
Hist.: OSP 1-1989, f. & cert. ef. 1-3-89; OSP 3-1989, f. 10-16-89, cert. ef. 10-15-89; OSP 5-1992, f. & cert. ef. 12-16-92; OSP 2-1995, f. & cert. ef. 10-20-95; OSP 1-1999(Temp), f. & cert. ef. 9-10-99 thru 3-7-00; OSP 1-2000, f. & cert. ef. 3-15-00; OSP 2-2000(Temp), f. & cert. ef. 7-14-00 thru 1-9-01; Administrative correction 6-12-01; OSP 1-2006, f. 3-29-06, cert. ef. 3-31-06; OSP 1-2009(Temp), f. & cert. ef. 8-6-09 thru 1-31-10; OSP 2-2009, f. 10-8-09 cert. ef. 1-1-10; OSP 3-2009(Temp), f. 12-18-09, cert. ef. 1-1-10 thru 6-29-10; OSP 3-2010, f. 6-1-10, cert. ef. 6-30-10; OSP 5-2010(Temp), f. 7-13-10, cert. ef. 7-14-10 thru 1-10-11; Administrative correction 1-25-11; OSP 4-2011, f. 9-2-11, cert. ef. 9-7-11; OSP 2-2016(Temp), f. & cert. ef. 11-18-16 thru 5-16-17

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Rule Caption: Rules prescribing policies and procedures for operation of the Statewide School Safety Tip Line
Adm. Order No.: OSP 3-2016(Temp)
Filed with Sec. of State: 12-13-2016
Certified to be Effective: 12-14-16 thru 6-10-17
Notice Publication Date:
Rules Adopted: 257-095-0000, 257-095-0010, 257-095-0030, 257-095-0040, 257-095-0050, 257-095-0060, 257-095-0070, 257-095-0080, 257-095-0090, 257-095-0100
Subject: These rules implement the Statewide School Safety Tip Line program, established by Oregon Laws 2016, Chapter 74. These rules provide:

- Provisions that protect the identity of a person reporting information without compromising opportunities for follow-up contact from local law enforcement contacts or service providers to provide further information to or obtain further information from the person;
- Written policies and procedures for:
- Logging reports received on the tip line;
- Verifying the authenticity and validity of a reported threat to student safety or potential threat to student safety;
- Relaying information concerning a threat to student safety or potential threat to student safety to local law enforcement contacts, service providers and appropriate education provider contacts;
- Connecting the tip line with other hotlines that are available for reports of violence or for crisis prevention; and
- Reporting for the purposes of tracking referrals to local law enforcement contacts and service providers resulting from information received on the tip line and tracking the outcome of any action taken in response to the referral.

Rules Coordinator: Shannon Peterson—(503) 934-0183

257-095-0000
Purpose of Rules

Rules adopted herein prescribe the policies and procedures for operation and use of the Statewide School Safety Tip Line Program (SSTL).

Stat. Auth.: ORS 165.570(2)
Stats. Implemented: ORS 165.570
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0010
Authority

(1) SSTL was established by act of the 2016 Oregon Legislature, Oregon Laws 2016, Chapter 47, authorizing the Department of State Police to establish and operate a statewide tip line for students and other members of the public to use to confidentially report information concerning threats to student safety or potential threats to student safety.

(2) Section 1(3) of Oregon Laws 2016, Chapter 47 requires the Department of State Police to adopt rules necessary to establish and operate the tip line.

(3) The SSTL is a program organized within the Public Safety Services Bureau of the Department of State Police.

Stat. Auth.: ORS 165.570
Stats. Implemented: ORS 165.570
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0030
Definitions

As used in ORS 165.570 and these rules:

(1) "Anonymous" means not identified by name.

(2) "Confidential Information" means any personally identifiable information acquired by the SSTL, its staff, schools, school districts, education service districts, service providers and responders, or information that is confidential under other state or federal law.

(3) "Cyberbullying" and "harassment, intimidation or bullying" have the meanings given those terms in ORS 339.351.

(4) "Local law enforcement contact" means a local law enforcement officer designated by the Department of State Police to be notified when the tip line receives a report of a threat to student safety or potential threat to student safety.

(5) "Personally Identifiable Information" means any information that would permit the identification of the person(s) reporting information and includes, but is not limited to, name, phone number, physical address, email address, and information that identifies the machine or device from which the person made the report.

(6) "Responder" means law enforcement, fire, emergency medical services and service providers receiving requests for assistance from the SSTL or directly from schools, school districts and educational service districts.

(7) "Service provider" means a person designated by the department to be notified when the tip line receives a report of a threat to student safety or potential threat to student safety. "Service provider" includes:

(a) A provider of behavioral health care or mental health care;

(b) A provider of school-based health care;

(c) A certificated school counselor;

(d) A clinical social worker licensed under ORS 675.530; or

(e) A professional counselor or a marriage and family therapist licensed under ORS 675.615.

(8) "Student" means a student of:

(a) A school district, as defined in ORS 332.002;

(b) A community college, as defined in ORS 341.005;

(c) A private school that provides educational services to kindergarten through grade 12 students;

(d) A career school, as defined in ORS 345.010; or

(e) A public university listed under ORS 352.002.

(9) "Threat to student safety" includes, but is not limited to, a threat or instance of:

(a) Harassment, intimidation or bullying or cyberbullying;

(b) Suicide or self-harm; and

(c) Violence against others.

(10) "Tip" means reports of information concerning threats to student safety or potential threats to student safety made by phone call, text message, email, web-form submission, or an application on a mobile device submission accepted by the SSTL.

(11) "Tip line" means a statewide resource designed to accept information concerning threats to student safety or potential threats to student safety through methods of transmission including:

(a) Telephone calls;

(b) Text messages;

(c) Electronically through the Internet; and

(d) Use of an application on a mobile device.

Stat. Auth.: ORS 165.570
Stats. Implemented: ORS 165.570
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0040
Responsibilities

(1) Department of State Police is responsible for:

(a) Establishing a statewide tip line for students and other members of the public to confidentially report information concerning threats or potential threats to student safety;

(b) The ownership and management of data entered into the SSTL;

(c) Following all records retention laws and other applicable laws and rules;

(d) Analyzing and interpreting data entered into the SSTL to help schools improve their response to safety issues;

(e) Maintaining strict confidentiality of confidential information received through tips, documents and communications submitted to the SSTL;

(f) Coordinating outreach and programmatic support to schools, school districts, Education Service Districts, law enforcement agencies and service providers involved in or entering the program;

(g) Following up and ensuring that tips are being dealt with and finalized;

(h) Generating analyses, reports and studies. Analysis, reports and studies shall contain only aggregated information and shall not contain any information that personally identifies reporters or any students;

(i) Reporting may involve tracking referrals and outcomes to local law enforcement and service providers from information received on the SSTL;

(2) The SSTL software vendor contracted by the Department of State Police is responsible for:

(a) Receiving SSTL tips via phone, email, application on a mobile device, website submission and text message as described in OAR 257-095-0060 and processing those tips;

(b) Ensuring adequate staffing of Tip Line Technicians to handle tip volume;

(c) Ensuring SSTL is functional and capable of operation 24 hours per day, seven days per week;

(d) Providing database access to designated persons at the Department of State Police, schools, school districts and other registered and authorized users of the SSTL and providing the ability to extract SSTL data for analysis;

(e) Following up on reported tips and documenting the status of tips through the SSTL;

(f) Prompting schools to provide updated responsible staff and responder contact information on a regular basis;

(g) Providing Physical and online information security protection including administrative, technical, and physical safeguards to protect assets and data from loss, misuse, unauthorized access, disclosure, alteration, and destruction.

(3) The schools, school districts or educational service districts are responsible for:

(a) Determining, keeping current, and providing to the SSTL lists of qualified staff and service providers capable of handling tips relayed to the school, school district or educational service district by the SSTL;

(b) Responding to tips appropriately;

(c) Forwarding tip information to law enforcement or service providers as appropriate;

(d) Following up on assigned tips, providing information about updates and outcomes to the SSTL to the extent not prohibited by any applicable federal and state confidentiality provisions, and closing tips through the SSTL.

(4) Responders receiving tips are responsible for following up on assigned tips, updating the status of assigned tips to the SSTL as needed and to the extent not prohibited by any applicable federal and state confidentiality provisions, and closing tips through the SSTL.

Stat. Auth.: ORS 165.570
Stats. Implemented: ORS 165.570
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0050
Incidents Reportable through the School Safety Tip Line Program

Threats to student safety or potential threats to student safety that are reportable to the SSTL include, but are not limited to harassment, intimidation or bullying, cyberbullying, suicide or self-harm and violence against others.

Stat. Auth.: ORS 165.570
Stats. Implemented: ORS 165.570
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0060
Receipt of Tips of Reportable Incidents

Tips received via the SSTL are classified and processed for appropriate school, school district or educational service district, law enforcement or service provider response.

(1) When the SSTL receives an incoming communication, the Tip Line Technician shall:

(a) Ask the caller's identity (for tips provided via phone and text) or confirm the identity of the person making the tip(for tips provided via website or application on a mobile device). If the person making the tip does not wish to disclose their identity, the Tip Line Technician shall also accept an anonymous tip;

(b) The Tip Line Technician shall immediately assess the situation and ensure that students (and others) are safe from harm. The Tip Line Technician may not delay in contacting responders and/or school officials if there is an immediate threat to safety;

(c) Tip Line Technicians will attempt to capture and confirm the following data by asking questions identified on templates. Components of this factual accounting process may include but are not limited to:

(i) Who is/was involved in the incident? The name of any person reported to be involved in the incident must be documented. The reporter may choose to be anonymous;

(ii) The school where the individual making the tip (if applicable) and student(s) involved are enrolled and the age of the students involved;

(iii) Specific details about the location of incident (i.e. building name/number, floor, room number, etc.);

(iv) Whether the individual reporting an incident is reporting about him/herself or another party;

(v) If more than one person is involved in the incident, the relationship, if any, those other individuals have to the school or school system;

(vi) What happened, (who did/said what to whom, etc.);

(vii) When the incident occurred (time and date, prior events if any);

(viii) Whether a school staff member notified, and how the school responded;

(ix) Whether treatment by a service provider was sought;

(x) Name of additional institutions/agencies involved.

(d) Tip Line Technicians will use their training and expertise to verify the authenticity and validity of a reported or potential threat to school safety.

(2) The SSTL software may capture Caller ID information, email addresses, and/or Internet Protocol (IP) addresses as part of the technical solution. This information will only be retrieved and used in accordance with Oregon Law and these rules.

(3) The Tip Line Technician shall log all tip information into the SSTL system and transmit the tip electronically to local law enforcement contacts, service providers and appropriate education provider contacts.

Stat. Auth.: ORS 165.570;
Stats. Implemented: ORS 165.570
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0070
Tip Examination, Classification and Referrals

(1) Once a tip is received by the SSTL, Tip Line Technicians shall classify the reported tip based on a pre-identified set of values to designate the level of threats to student safety and level of response needed;

(2) Tips received by Tip Line Technicians shall be referred to the appropriate school, school district or educational service district, service provider or law enforcement;

(a) Suspicious activity or non-criminal, school-safety concerns (i.e. general tips about bullying, suspicious behavior/actions discovered on social media, fights between students, reports of individuals on school grounds who may not have an appropriate reason for being there) will be routed to schools, school districts, educational service districts, school administrators, service providers and also to local law enforcement if the severity of the incident warrants a law enforcement response;

(b) Tips concerning potential criminal activity shall be forwarded to the appropriate law enforcement agency for that jurisdiction in addition to the notifications in subsection (2)(a);

(3) When an incoming tip received by the SSTL presents or appears to present a situation of immediate danger or threat of serious harm, the Tip Line Technician shall immediately contact the appropriate law enforcement, school, school district, ESD, or service provider relaying all known information about the tip;

(4) When Tip Line Technicians determine it appropriate based on the nature of the tip and their training and experience, they will forward the tip to other hotlines that are available for reports of violence or crisis prevention;

(5) Tips concerning gender-based harassment, intimidation, bullying or violence against students should also be referred to the school's appointed Title IX coordinator by the schools as per individual school policies;

(6) Tips or requests for social services that are not within the scope of the program will be referred to other hotlines or resources as available;

(7) The Tip Line Technician shall document in the SSTL system the person[s] to whom the tip was referred.

Stat. Auth.: ORS 165.570;
Stats. Implemented: ORS 165.570; ORS 343.041
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0080
Information Disclosure and Security

(1) Received data including pictures, video and other graphics contained in the SSTL software is confidential. Any entity or person authorized to receive information and data from the SSTL must use and disclose that information only as provided in these rules and authorized by law;

(2) The SSTL may not disclose the identity of any person who submits a tip. If a person making a report chooses to identify him or herself, they do so with the expectation that their identity shall be kept confidential and used only for investigatory purposes;

(3) The SSTL may release aggregated or summary tip information for reporting purposes but shall not release any confidential information. In order to protect the reporting process, limited updates may be provided as long as they do not violate any laws or policies;

(4) Photo, videos and other media images received of a sexual nature shall only be forwarded to law enforcement. Information regarding the tip can be sent to the school, but not the sexual images attached to the tip;

(5) A person who submits a tip to the SSTL may be contacted by the entity who has been assigned to respond to a tip if it is necessary to obtain further information;

(6) Information acquired by the SSTL will not be disclosed except as provided in these rules or as required by law.

Stat. Auth.: ORS 165.570
Stats. Implemented: ORS 165.570; 192.501(3), 192.502(4)
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0090
Anonymity

Persons submitting a tip via the SSTL may choose to identify themselves or to remain anonymous. If a person making a report chooses to identify him or herself, they do so with the expectation that their identity shall be kept confidential and used only for investigatory purposes.

Stat. Auth.: ORS 165.570;
Stats. Implemented: ORS 165.570
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

257-095-0100
Reporting and Data Analysis

(1) Information gathered in operation of the SSTL may be utilized for the purpose of generating reports to track outcomes of actions taken in response to a tip, or used to analyze and adapt the operation of the SSTL. Reports and analysis shall contain only aggregated information and shall not contain any information that personally identifies reporters or any students;

(2) SSTL data access is limited to schools, school districts, educational service districts, service providers and the Department of State Police;

(a) Schools, school districts and educational service districts shall only have access to their own school(s) or jurisdiction data for following up on tips, analysis, reporting and managing school policies;

(b) Schools are responsible for the appropriate dissemination of information to law enforcement, service providers, and other interested parties in accordance with these rules and any other applicable laws and rules;

(c) The Department of State Police shall have access to all SSTL information. The Department of State Police shall create annual and other reports as necessary. Reports shall contain only aggregated information and shall not contain any information that personally identifies reporters or any students.

Stat. Auth.: ORS 165.570;
Stats. Implemented: ORS 165.570
Hist.: OSP 3-2016(Temp), f. 12-13-16, cert. ef. 12-14-16 thru 6-10-17

Department of State Police, Oregon State Athletic Commission
Chapter 230

Rule Caption: Amendment changes requirement for mandatory pregnancy test to voluntary pregnancy test for female competitors.
Adm. Order No.: SAC 2-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 9-1-2016
Rules Amended: 230-020-0330
Subject: OAR 230-020-0330 All female competitors in boxing and mixed martial arts may voluntarily submit to a pregnancy test or in lieu of a pregnancy test a female competitor may sign a release of liability to compete. A female competitor who refuses to take a pregnancy test and refuses to sign a release of liability will not be allowed to compete in a boxing or mixed martial arts event.

This amendment changes the rule from mandating a pregnancy test to may voluntarily submit to a pregnancy test or sign a release of liability.
Rules Coordinator: Trista Robischon—(503) 378-3580

230-020-0330
Medical Disqualification

(1) The Superintendent or an authorized representative of the superintendent must refuse to certify a boxer or mixed martial arts competitor if the examining medical personnel or the Superintendent, or an authorized representative of the superintendent determines that withholding certification is necessary to preserve the health or safety of the boxer or mixed martial arts competitor.

(2) A boxer or mixed martial arts competitor is medically disqualified from competition if he or she:

(a) Has sustained a significant cut that is not completely healed;

(b) Has sustained three consecutive knockouts or TKOs, any knockout within the past 60 days, or any TKO within the past 30 days;

(c) Has sustained two knockouts within 90 days or a knockout in the first fight after a disqualification;

(d) Is not sufficiently conditioned to participate safely.

(3) A boxer or mixed martial arts competitor who has sustained three knockouts may be referred for neurological consultation.

(4) Pre-fight pregnancy test. Prior to participating in any boxing or mixed martial arts event, each female competitor will be offered the opportunity to take a pregnancy test at no cost to the competitor.

(a) Pregnancy tests may be administered during the pre-fight physical examination under the supervision of the examining medical personnel or an authorized female representative of the superintendent, using a pregnancy test kit supplied by the Commission.

(b) Pregnancy test kits not supplied by the Commission shall not be accepted.

(c) The female competitor shall be accompanied to the bathroom facility by the examining physician or authorized female assistant, shall be allowed to take the pregnancy test in privacy, and shall promptly provide the test to the examining medical personnel for interpretation of the results. The female competitor may not carry personal belongings into the bathroom while taking the test.

(d) In place of the pregnancy test described in subsection (b) of this rule, a female competitor may submit a results report from a serum or urine pregnancy test administered within 14 days of the scheduled event by a clinical laboratory or licensed physician. The competitor must submit the results report to the Commission no less than 72 hours before the event.

(e) A female competitor who tests positive for pregnancy may not participate in the boxing or mixed martial arts event for which the pregnancy test was submitted. A female competitor who fails to submit pregnancy test results or signed release consistent with all requirements of this rule may not participate in the boxing or mixed martial arts event for which the pregnancy test was requested. Nothing in this rule shall bar a competitor from seeking to establish eligibility to participate in subsequent events.

Stat. Auth.: ORS 463.113
Stats. Implemented: ORS 463.025 & 463.047
Hist.: BWC 1-1988, f. 3-22-88, cert. ef. 3-29-88; BWC 1-1991, f. & cert. ef. 9-20-91, Section (2) renumbered from 230-060-0150(2); BWC 1-1995, f. 10-10-95, cert. ef. 10-13-95; SAC 5-2008, f. 6-12-08, cert. ef. 7-1-08; SAC 1-2013, f. & cert. ef. 2-21-13; SAC 3-2013(Temp), f. & cert. ef. 7-10-13 thru 1-6-14; SAC 4-2013(Temp), f. & cert. ef. 7-10-13 thru 1-6-14; SAC 7-2013, f. & cert. ef. 11-5-13; SAC 2-2016, f. & cert. ef. 12-1-16

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

Rule Caption: Specifies DMV may issue a branded Oregon title based on information received from another jurisdiction
Adm. Order No.: DMV 8-2016
Filed with Sec. of State: 11-22-2016
Certified to be Effective: 11-22-16
Notice Publication Date: 10-1-2016
Rules Amended: 735-024-0015, 735-024-0025
Subject: To better protect Oregon vehicle consumers, DMV has amended its title brand rules to specify that in addition to ownership documents, DMV may consider information such as a vehicle record from another jurisdiction in determining whether to issue a branded Oregon title.
Rules Coordinator: Lauri Kunze—(503) 986-3171

735-024-0015
Definitions; Title Brands

As used in this rule through 735-024-0025, the following definitions apply:

(1) "Brand," "branded title," or "title brand" means a notation, inscription, indicator, symbol or phrase to indicate the history, condition, or circumstances of a vehicle. A title brand does not necessarily indicate the extent to which a vehicle may have been damaged, whether a vehicle has been repaired or to what degree a damaged vehicle has been repaired. A title brand may be:

(a) Printed, inscribed, stamped or otherwise affixed to a certificate of title; or

(b) Designated or recorded on the vehicle record of another jurisdiction.

(2) "Assembled vehicle" as defined in ORS 801.130 and these rules means a vehicle:

(a) With a body that does not resemble any particular year model or make of vehicle;

(b) That is not a vehicle rebuilt by a manufacturer;

(c) That is not a vehicle built in a factory where the year model and make are assigned at the factory; and

(d) That is not an antique vehicle, a vehicle of special interest, a reconstructed vehicle or a replica.

(3) The following title brands defined under this section are adopted pursuant to ORS 803.015 and 646A.405. Title brands indicate a determination of a vehicle's condition made by another jurisdiction, or in the case of "glider kit," "reconstructed," "replica vehicle," "totaled" or "Lemon Law Buyback," a determination made by Oregon DMV:

(a) "Branded" means:

(A) A listing of two or more brands on an out-of-state title or similar document; or

(B) A brand not specifically defined or identified under this rule.

(b) "Flood damaged," "flood," or a word of similar import means a brand to indicate that a vehicle has been submerged in water to the point that the vehicle sustained damage;

(c) "Glider kit" or a word of similar import means a brand to indicate:

(A) A kit consisting of a new truck cab or cab and hood assembly, including a front axle assembly and frame rails, with or without an engine, transmission and rear axle, manufactured and sold with a manufacturer's statement of origin, has been used to replace damaged or worn components of an existing heavy truck or tractor; or

(B) A heavy truck or tractor was assembled using a kit consisting of all new component parts, including engine, transmission and rear axle, manufactured and sold with a manufacturer's statement of origin, and assembled by a person other than the manufacturer of the components.

(C) For purposes of this subsection, "heavy truck or tractor" means truck or tractor with a gross vehicle weight rating of more than 16,000 pounds.

(d) "Lemon," "lemon-defective," "Lemon Law Buyback," "returned to manufacturer," or a word of similar import means a brand to indicate a vehicle was returned to the manufacturer because of a defect or condition that could not be corrected or repaired and that substantially impaired the safety, market value, or the use, or intended use, of the vehicle.

(e) "Previous damage" means a title brand issued by DMV prior to August 20, 2004, to indicate that DMV had received information from another jurisdiction that a vehicle was damaged, destroyed, wrecked or sal-

vaged, or words of similar import. The term "previous damage" does not apply to vehicles issued a junk title or similar ownership document by another jurisdiction as described under OAR 735-020-0070;

(f) "Reconstructed vehicle," or "reconstructed" as defined in ORS 801.408 and these rules, means either:

(A) A vehicle that:

(i) Has a body that resembles and primarily is a particular year model or make of vehicle;

(ii) Is not a vehicle rebuilt by a manufacturer;

(iii) Is not a vehicle built in a factory where the year model and make are assigned at the factory; and

(iv) Is not a replica; or

(B) A motor truck that has been rebuilt using a component kit if the manufacturer of the kit assigns a vehicle identification number and provides a manufacturer's certificate of origin for the kit.

(g) "Totaled vehicle" or "totaled" as defined in ORS 801.527 and these rules means a vehicle that:

(A) Is declared a total loss by an insurer that is obligated to cover the loss or that the insurer takes possession of or title to.

(B) Is stolen, if it is not recovered within 30 days of the date that it is stolen and if the loss is not covered by an insurer.

(C) Has sustained damage that is not covered by an insurer and the estimated cost to repair the vehicle is equal to at least 80 percent of the retail market value of the vehicle before it was damaged. For purposes of this subsection, "retail market value" shall be as reflected in publications relied upon by financial institutions doing business in this state, including but not limited to the Title and Registration Textbook of the National Automobile Dealers Association (N.A.D.A. Guide), the Automobile Red Book or the Kelley Blue Book .

(h) "Replica" as defined in ORS 801.425 and these rules, means a vehicle with a body built to resemble and be a reproduction of another vehicle of a given year and given manufacturer.

(4) "DMV" means the Driver and Motor Vehicle Services Division of the Oregon Department of Transportation;

(5) "Oregon Certificate of Title" or "Oregon title" means a certificate of title, as that term is defined in ORS 801.185, issued by DMV.

(6) "Oregon Salvage Title Certificate" means a written document issued by DMV under the provisions of ORS 803.140 and 819.016 as evidence of vehicle ownership. An Oregon Salvage Title Certificate is not an Oregon Certificate of Title.

(7) "Salvage title," "salvage certificate" and "dismantler (wrecker) bill of sale" means a document issued by another jurisdiction to indicate the vehicle has been damaged, wrecked or salvaged or words of similar import. "Salvage title" does not refer to an Oregon salvage title certificate as defined by ORS 801.454 and this rule, unless the Oregon salvage title certificate reflects a brand that indicates the vehicle was damaged in another jurisdiction, before being titled in Oregon.

(8) "Word(s) of similar import" means any word, term, indicator, symbol or phrase that means the same or has the same effect as the terms described under OAR 735-020-0070 (junk titles) and defined under sections (2) and (3) of this rule.

(9) For purposes of this rule, OAR chapter 735, division 024, division 152, ORS Chapters 819 and 822, "Auto Recycler" has the same meaning as "dismantler" as defined under ORS 801.236 and means a person issued a dismantler certificate under 822.110.

Stat. Auth.: ORS 184.616, 184.619, 646A.405, 802.010, 803.012, 803.015, 803.140, 819.016, 821.060

Stats. Implemented: ORS 646A.405, 803.015

Hist.: DMV 18-2004, f. & cert. ef. 8-20-04; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06; DMV 17-2009(Temp), f. & cert. ef. 9-29-09 thru 3-20-10; DMV 6-2010, f. & cert. ef. 2-25-10; DMV 8-2016, f. & cert. ef. 11-22-16

735-024-0025

Title Brands; When Issued, Removed and Exceptions

(1) When Issued. DMV will issue a branded title or a title with an "assembled" make when an application for an Oregon title is submitted and:

(a) The vehicle's title carries a brand(s) described under OAR 735-024-0015(2) and (3);

(b) DMV receives notice from a vehicle manufacturer to inscribe "Lemon Law Buyback" on the certificate of title for the vehicle;

(c) The vehicle meets the definition of an "Assembled vehicle" as defined under OAR 735-024-0015(2);

(d) The vehicle meets the definition of a "Reconstructed Vehicle," a "Replica" or a "Totaled vehicle" as those terms are defined under OAR 735-024-0015; or

(e) DMV determines from a previous title or vehicle record, including a record from another jurisdiction, from the application for title or from information obtained from any source, that a brand or "assembled" make should be placed on the Oregon title. DMV may require documentation to determine if a vehicle should be issued an Oregon title with a brand or "assembled" make.

(2) An Oregon title issued under section (1) of this rule:

(a) Will not necessarily be issued with the same brand that appeared on the vehicle's previous certificate of title or other ownership document or in another jurisdiction's record of the vehicle;

(b) Will be issued with a brand described under OAR 735-024-0015 determined by DMV to be most comparable to the brand that appeared on the previous certificate of title or in the vehicle's record. This subsection does not apply to a "branded" brand or an Oregon title with a "Lemon Law Buyback" brand;

(c) Will be issued with a brand described under OAR 735-024-0015 determined by DMV to be the most appropriate if DMV determines from information obtained from any source that a brand should be placed on the Oregon title.

(d) Will indicate the name of the jurisdiction that issued the title brand, unless the title brand was issued by DMV; and

(3) Except as specifically provided in section (4) of this rule, once a title brand or "assembled" make has been placed on a vehicle's Oregon Certificate of Title that brand or "assembled" make will appear on any subsequent Oregon title issued for the vehicle.

(4) DMV may omit, remove, add or change a title brand or "assembled" make when:

(a) DMV receives information that indicates an Oregon title or Oregon Salvage Title Certificate was issued with an incorrect brand or "assembled" make. For example, DMV receives written information from an originating jurisdiction that indicates its title incorrectly reflects a title brand;

(b) DMV is satisfied the title brand or "assembled" make was placed on the Oregon title or Oregon Salvage Title Certificate in error;

(c) DMV failed to place a title brand or "assembled" make on the Oregon title or Oregon Salvage Title Certificate when required under section (1) of this rule or subsections (d), (e) and (f) of this section.

(d) A subsequent accident or occurrence causes the vehicle to be identified with a brand or different brand such as "totaled," "reconstructed," or "Lemon Law Buyback."

(e) A vehicle issued an Oregon title with any brand or an "assembled" make other than totaled is reported to DMV as a totaled vehicle under ORS 819.012 or 819.014. Except as described in subsection (f) of this section, when DMV issues a new Oregon title it will include a totaled brand, which replaces any previous brand shown on the Oregon title. For example, a vehicle issued an Oregon title with a flood brand will be issued an Oregon title with a totaled-reconstructed brand when the vehicle is reported to DMV as a totaled vehicle and is subsequently titled as a reconstructed vehicle;

(f) Notwithstanding subsection (e) of this section, a vehicle issued an Oregon title with an "assembled" make, or glider kit, "Lemon Law Buyback," reconstructed or replica brand is reported to DMV as a totaled vehicle. If DMV issues a new Oregon title, it will include the original brand and a totaled brand. For example, a vehicle issued an Oregon title with a "replica" brand that is later reported to DMV as "totaled" under ORS 819.020 or 819.014, will be issued an Oregon title with a "replica-totaled-reconstructed" brand when the vehicle is reported to DMV as a totaled vehicle and is subsequently titled as a reconstructed vehicle; or

(g) The reason the vehicle was reported to DMV as a totaled vehicle is theft and the vehicle is recovered and no longer meets the definition of a "totaled vehicle" under ORS 801.527.

Stat. Auth.: ORS 184.616, 184.619, 646A.405, 802.010, 803.012, 803.015, 803.140, 819.016, 821.060

Stats. Implemented: ORS 646A.405, 803.015

Hist.: DMV 18-2004, f. & cert. ef. 8-20-04; DMV 10-2005, f. 3-18-05; DMV 17-2009(Temp), f. & cert. ef. 9-29-09 thru 3-20-10; DMV 6-2010, f. & cert. ef. 2-25-10; DMV 8-2016, f. & cert. ef. 11-22-16

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Department of Transportation, Highway Division
Chapter 734

Rule Caption: Contractor Performance Evaluations on Public Improvement Contracts for Highway and Bridge Construction
Adm. Order No.: HWD 3-2016
Filed with Sec. of State: 11-28-2016

Certified to be Effective: 11-28-16
Notice Publication Date: 10-1-2016
Rules Adopted: 734-010-0285
Rules Amended: 734-010-0290, 734-010-0300, 734-010-0320, 734-010-0330, 734-010-0340, 734-010-0360, 734-010-0380
Rules Repealed: 734-010-0350
Subject: This rulemaking revises the title of chapter 734, division 10 to accurately reflect the contents of the division, adds a definition rule for the division, repeals rule 350 which did not apply to contractor performance evaluations, clarifies the original intent of the rules that contractor performance evaluations remain on record for 36 months for the purpose of determining cumulative occurrences of unacceptable performance and required corrective action, separates performance levels 2 and 3 so occurrences at each level are treated independently in determining corrective action, eliminates redundant language and implements other minor typographical and grammatical edits.
Rules Coordinator: Lauri Kunze—(503) 986-3171

734-010-0285
Definitions

The following definitions apply to terms used in OAR 734-010-0290 to OAR 734-010-0380:

(1) "Authorized contractor representative" means the person authorized by the contractor to sign the prime contractor performance evaluation.

(2) "CAE" means ODOT's Contract Administration Engineer.

(3) "Contract" means public improvement contracts, as defined in ORS 279A.010(1)(bb), awarded by the Oregon Department of Transportation under authority of ORS 279A.050 and 366.205.

(4) "Contractor" means the individual or legal entity that has entered into a contract with ODOT.

(5) "CPM" means the Construction Project Manager who represents ODOT on the contract. The CPM may be an ODOT employee, local government representative, or consultant employed by ODOT or a local government.

(6) "DAS" means Oregon Department of Administrative Services.

(7) "Date of Second Notification" means the date on which required construction work, including change order work and extra work, has been satisfactorily completed, except for minor corrective work, and the recording of daily time charges cease.

(8) "Notice to Proceed" means written notice from ODOT authorizing the contractor to begin the work.

(9) "Occurrence" means each time a category or project total score falls within Performance Level 2 or Performance Level 3 on any performance evaluation.

(10) "ODOT" means the Oregon Department of Transportation.

(11) "OPO" means the ODOT Procurement Office.

(12) "Performance Level 1" is a performance evaluation range in which all of the scores on the performance evaluation set out under this rule fall into the acceptable category and do not require any corrective actions.

(13) "Performance Level 2" is a performance evaluation range designating a performance evaluation that has one or more scores that have fallen below Performance Level 1 and requires some level of corrective action depending on the cumulative number of occurrences on all contracts within a 36-month period.

(14) "Performance Level 3" is a performance evaluation range designating a performance evaluation that has one or more scores below the ranges set in Performance Level 2 and requires a higher level of corrective action beyond those required for Performance Level 2 depending on the cumulative number of occurrences on all contracts within a 36-month period.

(15) "SCME" means ODOT's State Construction and Materials Engineer.

(16) "Suspension" means action taken by ODOT to temporarily suspend a contractor's prequalification for a specified period of time.

(17) "Verifiable Receipt" means confirmation of receipt of email, facsimile or certified mail.

Stat. Auth.: ORS 184.616, 184.619, 279A.050, 279A.065, 279C.430
Stats. Implemented: ORS 279C.430
Hist.: HWD 3-2016, f. & cert. ef. 11-28-16

734-010-0290
Contractor Performance Evaluations

(1) This rule applies to contractors who must be prequalified to bid on ODOT contracts.

(2) Contractors who enter into contracts with ODOT shall have their performance evaluated on each contract. The evaluation will be scored on the basis of a numeric score and on an evaluation form provided by ODOT.

(3) The CPM shall complete the evaluation using the current version of ODOT Form 734-2884, "Prime Contractor Performance Evaluation." The form will also include a Contractor Evaluation Submittal page to document the results of the evaluation process.

(4) Contractor performance will be evaluated under five categories: management, safety, administration, regulatory compliance, and workforce and small business equity programs and on a total score of these five categories.

(5) The evaluation shall be conducted as follows:

(a) If the duration of a contract is 12 months or less, the CPM will complete one evaluation within 60 days of date of Second Notification for the contract; or

(b) If the duration of a contract is over 12 months, the CPM will complete an evaluation within 30 days of the anniversary date of the Notice to Proceed. In addition to annual evaluations, the CPM will complete an evaluation within 60 days of the date of Second Notification for the contract.

(6) Evaluations are valid for 36 months for purposes of determining the number of occurrences at Performance Level 2 or 3.

Stat. Auth.: ORS 184.616, 184.619, 279A.050, 279A.065 & 279C.430
Stats. Implemented: ORS 279C.430
Hist.: HWD 1-2005, f. 2-16-05, cert. ef. 3-1-05; HWD 12-2012, f. & cert. ef. 11-21-12; HWD 3-2016, f. & cert. ef. 11-28-16

734-010-0300
Scoring Contractor Performance Evaluation

(1) Each evaluation will result in six numeric scores. Scores will be assessed for each of the five specific performance categories, as well as an overall score. The overall score is a total amount of all five of the category scores. The evaluation scoring shall be conducted as follows:

(a) If the duration of a contract is 12 months or less, the CPM will score the evaluation for the entire duration of the project, or

(b) If the duration of a contract is over 12 months, the CPM will score the evaluation for the preceding year within 30 days of the anniversary date of the Notice to Proceed. The scores shall reflect only that time period and will not be a cumulative score for the project duration. The final evaluation shall be prepared within 60 days of the date of Second Notification and will reflect only that time period between the latest annual evaluation and the date of Second Notification.

(2) After the evaluation score has been calculated, the CPM will send the evaluation score by email, facsimile or certified mail to the authorized contractor representative. Within 14 days of the date of verifiable receipt of the evaluation, the contractor's authorized representative may sign and return the evaluation to the ODOT CPM or schedule a meeting with the CPM to review the evaluation. Signature and return of the form represents the contractor's acceptance of the evaluation.

(3) At the Review or Mandatory meeting with the CPM, the consequences and corrective actions should be discussed, in an effort to improve contractor performance on future projects and prevent future scores from falling into Performance Level 2 or 3.

(a) If an authorized contractor representative refuses to sign the evaluation form within 14 days of verifiable receipt or within 7 days following the meeting with the CPM, the CPM will sign and date the evaluation, note in the contractor's signature area "did not respond," and transmit a copy to the SCME.

(b) Following a Review meeting with the CPM, the authorized contractor representative may sign the evaluation or request an Appeal meeting with the CAE. The request for an Appeal meeting must be made within 7 days after the Review meeting with the CPM.

(c) If the contractor does not sign the form following the Review meeting with the CPM and does not request an appeal meeting with the CAE within 7 days after the review meeting with the CPM, the score is final and no appeal to the CAE for that evaluation shall be available.

(4) ODOT's Construction Section will forward the final evaluation to the authorized contractor representative by email, facsimile or certified mail with verifiable receipt indicating the date score became final.

Stat. Auth.: ORS 184.616, 184.619, 279A.050, 279A.065 & 279C.430
Stats. Implemented: ORS 279C.430
Hist.: HWD 1-2005, f. 2-16-05, cert. ef. 3-1-05; HWD 12-2012, f. & cert. ef. 11-21-12; HWD 3-2016, f. & cert. ef. 11-28-16

734-010-0320
Scoring Ranges and Corrective Actions

(1) There are three performance levels. The CPM will score each of the five evaluation categories as well as an overall evaluation score in one of the three performance levels. The contractor's authorized representative may request a Review meeting with the CPM within 14 days of verifiable receipt of the evaluation to discuss the evaluation score with the CPM.

(2) The following describes each performance level by identifying the scoring matrix for remedial actions and consequences depending on the cumulative number of occurrences during a 36-month period on all evaluations on all contracts.

(a) For all performance levels, scores are assessed on a per category basis, as well as a project total.

(b) Occurrences are considered on a per category basis, as well as the project total. [Table not included. See ED. NOTE.]

(4) The options available to the contractor at Performance Levels 2 and 3 are:

(a) Sign and return the evaluation to the CPM.

(b) Request a Review meeting with the CPM to discuss the evaluation score within 14 days of verifiable receipt. Following the Review meeting with the CPM, sign and return the evaluation to the CPM.

(c) Request an Appeal meeting with the CAE within 7 days from CPM Review meeting, to appeal the CPM's evaluation score.

(5) The CAE will schedule a meeting with the contractor within 14 days of receiving the contractor's request to appeal the score. Following the Appeal meeting, the CAE may uphold the CPM's evaluation score or adjust the score. The CAE's decision shall be made within 14 days of the Appeal meeting and the score is considered the final score.

(a) The contractor may choose to sign the evaluation form following the appeal to the CAE. Should the contractor choose not to sign the evaluation within 14 days of the appeal decision, the score becomes final without the contractor's signature.

(b) Following the Appeal meeting, the CAE will send the final evaluation/score by verifiable receipt to the authorized contractor representative indicating the date the score became final.

(6) The following table identifies the actions required for a final score under Performance Level 2 depending on the number of the occurrences in Level 2. Occurrences are considered on a per category basis, on a project total, and on the cumulative number of occurrences in Level 2 during the prior 36 month period on all evaluations on all contract. [Table not included. See ED. NOTE.]

(7) If the final evaluation score warrants any prequalification suspension, the contractor may appeal the suspension to DAS under OAR 734-010-0380.

(8) The following table identifies the actions required for a final score under Performance Level 3 depending on the number of the occurrences in Level 3. Occurrences are considered on a per category basis, on a project total, and on the cumulative number of occurrences in Level 3 during the prior 36 month period on all evaluations an all contracts. [Table not included. See ED. NOTE.]

(9) If the evaluation identifies that the contract was terminated for default, there is an automatic prequalification suspension for 6 months.

(10) If the final evaluation score warrants any prequalification suspension the contractor may appeal the suspension to DAS under OAR 734-010-0380.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619, 279A.050, 279A.065 & 279C.430
Stats. Implemented: ORS 279C.430
Hist.: HWD 1-2005, f. 2-16-05, cert. ef. 3-1-05; HWD 12-2012, f. & cert. ef. 11-21-12; HWD 3-2016, f. & cert. ef. 11-28-16

734-010-0330
Corrective Action Plan

(1) The purpose of the corrective action plan and the meeting with the SCME is to help the contractor improve performance, project delivery, and avoid low ratings in the future. The tables shown in OAR 734-010-0320 identify remedial actions based on the number of occurrences using cumulative category and total project scores for 36 months on all evaluations on all contracts. If a contractor's performance requires submission and approval of a corrective action plan, the SCME will notify the contractor in writing.

(a) The authorized contractor representative must contact the SCME within 14 days of verifiable receipt of notice from the SCME to schedule a meeting to present a written corrective action plan. The parties must meet within 21 days of the date the contractor's representative contacts the SCME or within an otherwise agreed timeframe.

(b) The contractor will be allowed to bid and receive award for any proposal submitted until the parties meet within 21 days or otherwise agreed timeframe.

(c) After the 21 days or otherwise agreed timeframe has expired, if the contractor has not presented a corrective action plan acceptable to the SCME, the contractor will not be allowed to bid or receive award again until a corrective action plan has been submitted and approved by the SCME.

(2)(a) If a contractor's evaluation score requires suspension of the contractor's prequalification, a written corrective action plan must be submitted to and approved by the SCME no later than 30 days prior to the end of the prequalification suspension period.

(b) If the corrective action plan is not submitted and approved by the SCME at least 30 days prior to the end of suspension, the contractor's prequalification will remain suspended until the corrective action plan is approved by the SCME.

(3) When the SCME approves the corrective action plan submitted by the contractor, the SCME shall notify by verifiable receipt the authorized contractor representative and the OPO Construction Contracts Manager.

(4) The OPO Construction Contracts Manager will notify by verifiable receipt the authorized contractor representative, once the contractor's prequalification is reinstated.

Stat. Auth.: ORS 184.616, 184.619, 279A.050, 279A.065 & 279C.430
Stats. Implemented: ORS 279C.430
Hist.: HWD 1-2005, f. 2-16-05, cert. ef. 3-1-05; HWD 12-2012, f. & cert. ef. 11-21-12; HWD 3-2016, f. & cert. ef. 11-28-16

734-010-0340
Notification of Suspension from Bidding

(1) The SCME will notify OPO's Construction Contracts Manager when a contractor's evaluation scores result in suspension of pre-qualification.

(2) The OPO Construction Contracts Manager will notify by verifiable receipt the authorized contractor representative that its score has fallen below an acceptable level and that its prequalification has been suspended.

(3) The contractor may appeal a suspension through DAS by requesting a DAS appeal within 7 days of receipt of the suspension notice, as specified in OAR 734-010-0380.

(4) In all cases, any notification of suspension and reinstatement shall be made in writing and sent to the authorized contractor representative by the OPO Construction Contracts Manager.

(5) The effective date of a suspension will be:

(a) 10 days after the date of the OPO Construction Contracts Manager's notification; or

(b) 10 days after the date any appeal becomes final when the decision to suspend is upheld by DAS.

Stat. Auth.: ORS 184.616, 184.619, 279A.050, 279A.065 & 279C.430
Stats. Implemented: ORS 279C.430
Hist.: HWD 1-2005, f. 2-16-05, cert. ef. 3-1-05; HWD 12-2012, f. & cert. ef. 11-21-12; HWD 3-2016, f. & cert. ef. 11-28-16

734-010-0360
Effect of Suspension on Business

(1) Any prequalification suspension shall be binding upon the following:

(a) Any contractor suspended according to 734-010-0320;

(b) Any business with which such contractor's owners, officers, directors or managing agents are associated;

(c) Any subsidiaries, affiliates, parent corporations, joint ventures, successors, assigns of the contractor; and

(d) Any entity in which the contractor, its owners, officers, directors and managing agents are owners, majority shareholders or such persons own in the aggregate a majority of shares, partners, directors, officers or agents, other than in a capacity solely as an employee of that other entity or business.

(2) Such suspensions of these other entities and businesses shall apply continuously during the contractor's period of suspension.

Stat. Auth.: ORS 184.616, 184.619, 279A.050, 279A.065 & 279C.430
Stats. Implemented: ORS 279C.430
Hist.: HWD 1-2005, f. 2-16-05, cert. ef. 3-1-05; HWD 3-2016, f. & cert. ef. 11-28-16

734-010-0380
DAS Appeal Process Covering Contractor Evaluations

(1) In the event that a contractor's prequalification is suspended by ODOT, the contractor may appeal the suspension to DAS in accordance with ORS 279C.445 and 279C.450. If the contractor wishes to appeal suspension of its prequalification as a bidder to DAS, the contractor must,

within 7 business days after receipt of notice of suspension, notify the OPO Construction Contracts Manager in writing.

(2) Upon receipt of such notice of appeal, the OPO Construction Contracts Manager will immediately notify the Director of DAS and the SCME.

(3) The Director of DAS will notify the appealing party and ODOT of the time and date of the hearing. The hearings appeal and final decision will take place in accordance with the statutory requirements and applicable DAS rules.

(4) If the suspension is upheld, the OPO Construction Contracts Manager will notify the contractor and the SCME that the suspension of the contractor's prequalification will begin 10 days after the contractor is notified.

Stat. Auth.: ORS 184.616, 184.619, 279A.050, 279A.065 & 279C.430
Stats. Implemented: ORS 279C.430
Hist.: HWD 1-2005, f. 2-16-05, cert. ef. 3-1-05; HWD 12-2012, f. & cert. ef. 11-21-12; HWD 3-2016, f. & cert. ef. 11-28-16

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Rule Caption: Outdoor Advertising Sign Program miscellaneous rule updates
Adm. Order No.: HWD 4-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 11-28-16
Notice Publication Date: 10-1-2016
Rules Adopted: 734-060-0180
Rules Amended: 734-059-0015, 734-059-0200, 734-060-0000, 734-060-0175, 734-060-0190, 734-065-0010, 734-065-0015, 734-065-0020, 734-065-0025, 734-065-0035, 734-065-0040, 734-065-0045
Rules Repealed: 734-060-0010
Subject: These rules are amended to:

1. Update incorrect reference, and add language in the definitions portion of chapter 734 that will assist the Department in communicating the scope of certain rules as they apply to the location of outdoor advertising signs.

2. Clarify the requirement to inform the Department of ownership changes of outdoor advertising sign permits or permitted signs removed from permitted locations

3. Consolidate all transit bench/shelter sign rules into Division 65.

4. Modify limits on temporary sign variance to better accommodate needs of citizens.

5. Add language to address limited or restricted permits for non-conforming signs.

6. Clarify standard for digital and LED signs at a place of business that are visible to a state highway.

Rules Coordinator: Lauri Kunze—(503) 986-3171

734-059-0015
Definitions

(1) The terms "neat," "clean," "attractive" and "good repair" as used in ORS 377.710(17) and 377.720(7) are defined as follows:

(a) The terms "neat" and "attractive" mean without rotting or broken parts, having parts that are solid and sound, without chipping or peeling paint, paper, vinyl or plastic, without graffiti, and without faded, washed-out or illegible copy. The terms apply to all component parts of a sign.

(b) The term "clean" means free of dirt, unsoiled, without grime or soot. The term does not include a minor dust coating that is undetected from the main-traveled way of a state highway. The term applies to all component parts of a sign that are visible to the main-traveled way of a state highway.

(c) The term "good repair" means having sound and solid parts, without rotting or broken parts, firmly fixed in place so as to be able to withstand a wind pressure of 20 pounds per square foot of exposed surface. The term includes all component parts of a sign.

(2) In interpreting ORS 377.720(9), to be considered "used in transportation" the owner or operator must demonstrate the vehicle or trailer is regularly used in a manner consistent with its usual purpose. The Department may consider but is not limited to the following factors:

(a) Whether it is used only for storage;

(b) Whether it is incapable of being moved in its normal way, such as due to a flat tire or mechanical problems;

(c) Whether its movement would be illegal such as if its registration has expired;

(d) Whether its location is compatible with being regularly used in transportation;

(e) How frequently it is moved;

(f) How far it is moved;

(g) Whether any change in location appears to be a mere attempt to qualify a sign structure under the exemption.

(3) In interpreting ORS 377.773, "abandoned" means any sign that does not have a message on the display surface for a period of six months, a sign for which there is no display surface for a period of six months or a sign whose structure has been removed for a period of six months. For abandoned signs under ORS 377.773 the sign permit may be canceled at the end of the 6-month period.

(4) In interpreting ORS 377.700 to 377.844 and 377.992 the term "person" includes individuals, joint ventures, partnerships, corporations and associations or their officers, employees, agents, lessees, assignees, trustees or receivers.

(5) In interpreting ORS 377.700 to 377.844 and 377.992 an Outdoor Advertising Sign Permit Owner is a single person, or their authorized representative, who holds the right to authorize an activity associated with the permit including sign reconstruction, direct relocation, relocation credit request or the sale of a sign permit or relocation credit.

(6) For a sign to be considered at a place of business or activity open to the public, for the purposes of the outdoor advertising sign program, some portion of regularly used buildings, parking lot, or storage or processing area must be visible from the state highway, with signage placed on, or immediately adjacent to, those portions of the business or activity.

(7) In interpreting ORS 377.735(1)(b)(C) a residence means a dwelling, grounds and physical areas necessary or customarily incident to the dwelling including garages, barns, yard, and parking and garden areas, arranged to be used in immediate connection with the dwelling and its customary residential uses. Fields used for crops or grazing are not considered a part of the residence for the purposes of the sign program.

Stat. Auth.: ORS 184.616, 184.619, 377.710 & 377.720
Stats. Implemented: ORS 377.720
Hist.: TO 4-2002, f. & cert. ef. 4-15-02; HWD 1-2009, f. & cert. ef. 2-20-09; HWD 11-2014, f. & cert. ef. 12-19-14; HWD 4-2016, f. & cert. ef. 11-28-16

734-059-0200
Civil Penalties for Violation of the Oregon Motorist Information Act

(1) This rule establishes the factors for consideration in assessing, reducing, or waiving civil penalties created by ORS 377.992 for violation of ORS 377.700 to 377.840, the Oregon Motorist Information Act, and related statutes and rules, and a process for implementing those penalties. These are in addition to any other penalty provided by law, including but not limited to assessing costs, removing signs, and canceling permits.

(2) The definitions in ORS 377.710 and OAR 734, division 059 apply to this rule. The following also apply to this section:

(a) "First time violator" means a person with no Final Order of violation of the Oregon Motorist Information Act or related statutes and rules within five years of the issuance of the violation notice.

(b) "Repeat violator" means a person with only one sign for which the Department issued a Final Order of violation of the Oregon Motorist Information Act or related statutes or rules within five years of issuance of the current violation notice, but who is not a habitual violator.

(c) "Habitual violator" means a person with more than one sign for which the Department issued a Final Order of violation of the Oregon Motorist Information Act or related statutes or rules within five years of the issuance of the current violation notice.

(d) The five-year period noted in 2(a) through 2(c) commences on the date of an Order finding a violation, and any notice of subsequent violation within that five years is a further violation if the department issues an Order finding a violation, whether or not the Final Order is within the five year period.

(e) "Person" is defined in ORS 756.010(5).

(3) A person who violates The Oregon Motorist Information Act or related statutes or rules is subject to a civil penalty as provided in this section. Civil penalties begin to accrue 31 calendar days from the date of the notice of violation beginning at 12:01 a.m. of the 31st calendar day and end with the complete correction or the complete removal of the sign either by the sign owner or by the Department at the Department's discretion.

(4) The Department may assess a penalty up to $50 per day for violation of ORS 377.720(5), 377.720(6), 377.720(9), 377.730(1), or 377.773. The Department may assess a penalty of up to $50 per day for violation of 377.725(12), except if the Department finds the owner intentionally installed the wrong permit plate in an effort to delay or avoid enforcement, in which case the Department may assess a penalty of up to $1000 per day.

(5) The Department may assess a penalty of up to $500 per day for first time violators of ORS 377.510, 377.725(1) or (2), 377.735(1)(b), 377.740, 377.745, 377.750, 377.767(2), 377.767(5).

(6) The Department may assess a penalty of up to $1000 per day for first time violators of ORS 377.720(1) through (4), (7) or (8), or 377.730(3).

(7) Repeat and habitual violators may be assessed up to the maximum penalty in ORS 377.992. For any violation not specifically cited in this rule, the Department may assess against any violator up to the maximum penalty in ORS 377.992.

(8) For any violation, in lieu of the per day amounts otherwise described, the Department may assess as a civil penalty the gross revenue derived from the sign at issue from the 31st day after notice of violation until the violation is corrected or the sign removed.

(9) The Department may consider all relevant facts in assessing, reducing, or waiving a civil penalty. The Department may consider but is not limited to the following factors:

(a) Whether the owner is a first time violator, repeat violator, or habitual violator, and how many of the owner's signs have previously been in violation of the OMIA.

(b) Whether the owner, its agents or employees responsible for the sign at issue were previously involved with another owner, and whether that previous owner had no violations, was a first time, repeat, or habitual violator.

(c) The amount of time between the Department issuing a violation notice and the contested case hearing, and whether any delay was due to reasons outside the control of the violator.

(d) The cooperation of the owner in dealing with the Department, including:

(A) Promptness in responding to requests for information;

(B) Accuracy and completeness of information provided;

(C) Assertion of frivolous issues or defenses;

(e) The complexity of the issues involved;

(f) The value of the public interest involved;

(g) Public comment about the sign at issue.

(10) If the final order resulting from an administrative hearing renders the Department's enforcement incorrect, civil penalties do not accrue to the sign in question.

(11) For the convenience of the public, the Department will produce a summary of the types of violations and maximum penalties allowed, factors that may be considered, and any other relevant information regarding assessment of penalties.

Stat. Auth.: ORS 184.616, 184.619, 377.992

Stats. Implemented: ORS 377.992

Hist.: TO 2-2002, f. & cert. ef. 2-19-02; HWD 11-2010, f. & cert. ef. 9-27-10; HWD 4-2016, f. & cert. ef. 11-28-16

734-060-0000

Outdoor Advertising Sign Application Process

(1) Application forms. An application for a sign permit under the Oregon Motorist Information Act (OMIA) is made by completing and submitting the appropriate form, attaching to the form all documents necessary to show the application meets the requirements of the law, and submitting the correct fee to the Outdoor Advertising Sign Program of the Oregon Department of Transportation. Application forms are available from the Outdoor Advertising Sign Program. There are three different Outdoor Advertising Sign application forms: "Standard Outdoor Advertising Sign Permit Application" for new permits for outdoor advertising signs that pre-existed the law change on May 30, 2007, relocations and reconstructions of such permitted signs; "Digital Billboard Outdoor Advertising Sign Application" for digital permits newly issued under ORS 377.710, or relocation and reconstruction of such permitted signs and "Application for Transit Bench or Shelter Sign" for signs on bus/transit benches and bus/transit shelters. The Department may deny a permit application if the applicant does not use the correct form.

(2) Copies of sign laws. The Department will make available copies of all state sign statutes, administrative rules, federal statutes, federal regulations, and federal-state agreements in effect. The Department may charge for the copies at the rate established by law for public records requests, and may require prepayment. The Department may also provide these documents by e-mail, web site, or in other forms for the convenience of the public and the Department.

(3) Summary of regulations. To assist potential permit applicants and the general public, the Department will make available a summary of sign permit regulations. The summary does not bind the Department to the items listed or waive its right and duty to enforce all requirements under the law.

(4) Contents of applications for Standard Outdoor Advertising Signs and Digital Billboard Outdoor Advertising Signs. To be complete the application must include the following.

(a) Application form Part 1: Applicant Information, Sign Specifications. Information must be complete and accurate for applicant, sign builder, purpose of application, description, township/range/section/tax lot, highway route number or name and side of highway, how site is marked, name and address of property owner, and why the sign will be an "outdoor advertising sign." The location boxes should be completed to the best of applicant's ability to enable the Department to find the site.

(b) Application form Part 2: Certification of Applicant. The application form must be signed and dated by the applicant, certifying the information provided by applicant is accurate and has not been changed after the local government certification (see section (c) below). If the applicant is a corporate or other business entity the individual signing must include their title so as to indicate the authority to sign for the applicant.

(c) Application form Part 3: Certification of Local Jurisdiction. After completing Part 1, applicant must submit the complete application to the local jurisdiction for zoning and local compliance information. The local official must complete Part 3 and, if relevant, attach a letter of explanation of local code compliance. The local official must sign and date Part 3.

(d) Fee. The fee is based on square footage as described in OAR 734-059-0100. To be complete applicant must submit the correct application fee. The Sign Program does not accept cash, debit or credit cards; checks must be made out to Oregon Department of Transportation.

(e) Written proof of landowner consent. All applications must include written proof that the landowner consents to have applicant maintain the proposed sign. The document must be signed by the landowner and the application filed during the base term of the agreement, or during a renewal term that is automatic or at applicant's election. If during a renewal period applicant must certify that the renewal was exercised and continues in effect. Examples of acceptable documents are the land lease, land lease plus applicant's certification as described above, land lease plus owner's written confirmation that an extension is being exercised, or a current memo signed and dated by land owner stating that applicant has permission to put the sign at the specified location. Payment information need not be included unless it is the evidence that compensation is exchanged making it an outdoor advertising sign.

(f) Business License. The applicant and the sign builder must have a current outdoor advertising sign business license as required under ORS 377.730. It is the responsibility of the Business License holder who erects or maintains an outdoor advertising sign to ensure that the outdoor advertising sign, visible to a state highway, is in compliance with the OMIA. Compliance includes ensuring signs have an active state sign permit prior to placing or maintaining any message on the sign, and ensuring that the sign stays in compliance during the time that the licensee operates or maintains the sign. Violations may result in suspension or revocation of the licensee's business license as allowed under ORS 377.730.

(g) Relocation permit application. For a relocation application, if the zoning was first commercial or industrial after 1/1/1973, or if the local jurisdiction cannot determine the date, the applicant must submit a sketch or other document showing the site is within 750 feet of a commercial or industrial area to comply with ORS 377.767(3).

(h) Pre-existing sign permit application. For an application for a new pre-existing sign under ORS 377.712 the following additional items are required:

(A) Complete the application form "Supplement for Pre-existing Sign Permit" and sign it before a notary public;

(B) Submit documents demonstrating each of your claims, such as a lease showing the sign was posted for compensation; and

(C) Pursuant to ORS 377.712(1), include documentation demonstrating how applicant was ignorant of the permit requirement for outdoor advertising signs as of May 30, 2007.

(5) Digital Billboard applications must also include the following information:

(a) When being reconstructed or relocated for the first time as a digital billboard the applicant must provide the eligible permit(s) or relocation credit(s) being retired pursuant 377.700 to 377.840 and OAR 734-060-0007.

(b) Whether the proposed sign is a "Poster," "Bulletin," or other sign as described in OAR 734-060-0007(2).

(c) Emergency malfunction contact information including name, phone number along with proposed response procedure to possible malfunction.

(d) Whether or not a renewable energy resource is available and being utilized. If none, then the applicant must complete the affidavit attesting that no renewable resource is available.

(6) Transit Bench or Shelter Application. A transit shelter or bus bench application must provide documentation demonstrating that the site is at an official bus or transit stop on a city or urban transit system route.

(7) Complete Applications.

(a) The Outdoor Advertising Sign Program's mailing address is: Oregon Department of Transportation, Right of Way Section — Sign Program, 4040 Fairview Industrial Drive SE, MS #2, Salem OR 97302. The Sign Program receives hand deliveries at 4040 Fairview Industrial Drive SE, Salem Oregon. The Sign Program receives facsimiles at 503-986-3625. The Sign Program receives electronic mail at OutdoorAdvertising@odot.state.or.us.

(b) The Department requires original signatures and original initials to any changes on the application form. Therefore the Department will not accept the application form by electronic transmission (including facsimile). The Department may accept other documents by electronic transmission. The Department will not accept any changes made verbally; all changes must be in writing.

(c) The Department will indicate on each application document the date and time received. Application materials received by mail will be treated as received at the time a representative of the sign program physically receives the program's mail for that day. Application materials received in person, by fax, or by electronic transmission will be treated as received when a representative of the sign program physically receives those materials.

(d) The Department will only process applications that are complete. An application is complete when the Outdoor Advertising Sign program receives the signed application form including all necessary information, all documents necessary for issuance of a permit, and the correct application fee.

(A) Within 15 calendar days of receiving an application the Department will provide to the applicant written notice whether the application is complete. If the Department determines the application is complete, the notice will state the application's priority among all pending, complete applications.

(B) If the Department determines any information provided is incorrect, the application is not complete. The Department may rescind a notice of completeness and priority date if it later determines that information provided by applicant is not correct.

(e) If an application is not complete, within 15 calendar days of receiving the application the Department will return a copy of the entire application with written instructions on what is needed to complete it. The applicant must initial any subsequent changes and, if the changes are substantive to the local jurisdiction, must obtain a new certification from the local jurisdiction. The Department will retain the application for 60 days. If the application is still incomplete after 60 days, it will be deemed withdrawn by the applicant. The Department may retain the original application as a record.

(A) If an application form is complete but the application is considered incomplete due to insufficient supporting documents or failure to submit the fee, the Department may return a copy of any relevant portion of the application with written instructions on how to complete it or the Department may hold the application and notify the applicant in writing of what is needed and when it must be provided.

(B) Within 15 days of receiving the corrected form or additional materials the Department will provide the applicant written notification whether the application is complete and, if complete, the priority among all pending, complete applications.

(C) If the applicant makes any change to the application after it is deemed complete, the Department will change the priority date to the date of that change.

(D) If the Department has held an incomplete application for 60 days from the date of initial receipt, the application is deemed withdrawn by the applicant. The Department will return a copy of the application and may refund any eligible deposited fee. The Department may retain the original application as a record.

(8) Processing of complete permit application.

(a) The Department will approve or deny a permit within 60 days of the complete application's priority date as determined under section (7)(d) or (e) of this rule if the application clearly does not conflict with another complete application.

(b) An application for a permit that conflicts with the location of an expired or canceled permit will not be processed until the time for any hearing or appeal on the latter permit has passed, unless the permit is being canceled as a condition for issuance of the new permit.

(c) When a complete application might conflict with another complete application due to spacing or any other reason, the application with the earliest priority date and time takes precedence over later applications. Subject to all other requirements of the OMIA, the Department will issue the permit to the earlier applicant.

(d) If multiple complete applications have the same priority date and time, and are determined by the Department to compete for the same spot, the Department shall notify the applicants of the circumstances within seven days of the Department's determination. If an affected applicant requests a contested case hearing, the matter will be determined by a single contested case hearing under Oregon's Administrative Procedures Act. The Department shall refer the matter to the Office of Administrative Hearings within seven days of an applicant's written hearing request.

(e) If the Department does not approve or deny a permit application within the time allowed under section (8)(a) of this rule, such actions do not require the Department to issue a permit or require any remedy except as provided otherwise in law.

(9) Field checks; applicant requirements and Department method.

(a) When the Department determines an application is complete, the Department will perform a field check to determine the milepoint and all other information necessary to process the application.

(b) The applicant must place a marking at the site to show the proposed location for the sign permit. The applicant may use a stake, ribbon, paint, or any method or material that will allow the Department to easily locate the site and attribute it to the applicant. If the marked site is other than that represented to the local authority in obtaining its signature on the application form, or is other than where the applicant actually builds the sign, the Department may consider that a violation of ORS 377.725(10).

(c) If the Department cannot locate the site it will notify the applicant pursuant to (5)(e) above that the application is incomplete due to incorrect information and may request reasonable action by the applicant to identify the site.

(d) The Department will conduct a field check by traveling to the proposed site and calculating the milepoint to the one-hundredth of a mile or, when necessary, to the one-thousandth of a mile. The Department may also determine the engineering station. The Department may also make any other determination regarding the site that is relevant to the application, such as proximity to the right of way and to a commercial or industrial area. Once a field check has been conducted the application fee is non-refundable.

(e) The Department may use intersections, highway structures, or other highway feature and its corresponding milepoint or engineering station, to measure and calculate the milepoint of the proposed site. Milepost markers are for the convenience of motorists and are not precise indications of the milepoint, therefore the Department will not use milepost markers for these calculations without other indication of accuracy.

(10) Denied Permit Applications. If the Department denies an application, it will consider that site as conflicting with other applications:

(a) Until the time to request a hearing elapses without a hearing request from the applicant; or

(b) If a hearing is requested, until the time to request an appeal on the final order has elapsed or until the final appellate court enters a judgment on the matter, whichever is later.

(c) The Department will keep the original application and any accompanying documents and return a copy after an application is denied.

(11) Issued Permits.

(a) The permit will specify the 180th day by which the sign must be constructed.

(b) Within 190 days of permit issuance, the permittee must notify the Department in writing if the action described in the permit has been completed, and include at least one photograph demonstrating that completion. For a reconstruction permit or a relocation permit based on a relocation credit, the notice must state that the new sign has been constructed. For a direct relocation the notice must state that the new sign has been constructed and the former sign on which the permit was based has been removed. If the Department has not received the notification within 180 days the Department will alert the permittee about the upcoming 190-day deadline. If the permittee fails to submit the written notice and photograph within the time allowed, the Department will cancel the permit to relocate or reconstruct, and the permit will revert to its prior status. No fees will be refunded.

(c) "Constructed" means that the structure and all sign faces are permanently in place and the permit plate is attached. "Removed" means the

taking down, removing, or eliminating all sign structure elements that are visible from the state right of way.

(12) Sign Removal Notification A written relocation credit request and the accompanying relocation credit banking fee must be provided to the Department by the permit holder within 60 days of the removal of any permitted sign for that sign to be eligible to receive a relocation credit.

(13) Notification of Ownership Change It is the responsibility of a Business Licensee and a Permit Owner to notify the Department of ownership changes, in writing, within 60 days if a sign permit or relocation credit has been transferred to a new owner or licensee. Failure to provide written notification and required transfer fees within 60 days may be considered a violation under ORS 377.725(2) and may result in the suspension of associated Business License(s).

Stat. Auth.: ORS 184.616, 184.619, 377.715, 377.725
Stats. Implemented: ORS 377.715, 377.725
Hist.: HWD 2-2009, f. 3-20-09, cert. ef. 3-23-09; HWD 9-2011(Temp), f. 8-24-11, cert. ef. 9-29-11 thru 3-26-12; HWD 6-2012, f. & cert. ef. 3-26-12; HWD 11-2014, f. & cert. ef. 12-19-14; HWD 4-2016, f. & cert. ef. 11-28-16

734-060-0175
Temporary Signs

(1) This rule is enacted pursuant to ORS 377.735 regarding the permit exemption for temporary signs and in furtherance of the Oregon Motorist Information Act (OMIA, 377.700 through 377. 840 and 377.992).

(2) Location generally. A temporary sign may be erected outside of state highway right of way, within view of a state highway, subject to the requirements of the local jurisdiction and the OMIA. A sign that complies with all the provisions of ORS 377.735(1)(b) may be erected without prior approval of the Department. A sign that requires a variance to comply must obtain that variance before erecting the sign. The Department may, at its discretion, retroactively grant a variance.

(3) The entire message must be contained on one sign. Fragmentation of messages on separate sign panels is prohibited.

(4) Changes in copy or location. For the sake of the time limits described in ORS 377.735(1)(b), the following will be considered one sign:

(a) The same sign structure, regardless of copy, moved less than 600 feet from a former site; or

(b) A different sign structure, regardless of copy, in approximately the same location as another sign that was removed.

(5) Variance Procedure.

(a) A variance request must be in writing on a form provided by the Department. The request must be sent to the Outdoor Advertising Sign Program. There is no fee for a variance.

(b) A variance request must describe the specific location including:

(A) Name or number of highway;

(B) Side of highway; and

(C) Approximate milepoint, distance from a known highway feature (e.g. an intersection), or physical address.

(c) A variance request must describe the reason that constitutes good cause to grant the variance. If a reason is the amount of copy itself, requester must include the proposed copy. The Department may consider the amount, not the substance, of the copy.

(d) The request must include the name and mailing address of the requester. If the requester wants the Department to be able to make contact in any other way, such as to obtain supplemental information to process the request, requester may also include that contact information. The requester will be considered a sign owner for the sake of violation of sign laws.

(e) The request must include the date the sign will be posted and the date it will be removed so as to comply with the time limits to qualify for the exemption.

(f) Requester must certify that he or she:

(A) Has permission from the person in control of the property to post the sign;

(B) Will comply with all requirements of the local jurisdiction;

(C) Will not pay or receive any form of compensation for posting the sign; and

(D) Will comply with all requirements of the OMIA.

(g) The Department must grant or deny the request within 14 days after the Outdoor Advertising Sign Program receives it. The Department may deny applicant's variance request due to lack of required information; the applicant may re-submit the request. If the Department denies a request, fails to make a decision within 14 days, or grants and later revokes a variance, the requester may request a contested case hearing. Failure of the Department to meet the time limits required by this rule does not require that the variance be granted.

(h) If the Department determines a requester provided false information, including a false certification under (3)(f), it may deny the request and revoke any variance already granted to that person or the organization the applicant represents.

(i) Variances for both size and time may be granted at the discretion of the Department based on motorist safety considerations and statutory requirements. The Department will not grant more than 10 variances to one requester or organization for the same period of time.

(6) Specific Variance Criteria.

(a) Variance for size. The Department may grant a variance for size up to 32 square feet per side of a back-to-back sign. Good cause to grant a size variance may include, but is not limited to the following:

(A) Due to highway speed, width of right of way, topography, or other similar reasons beyond the applicant's control, the sign copy will not be legible to motorists if the sign is 12 square feet or less;

(B) Due to the amount of copy on the sign, the copy will not be legible to motorists if the sign is 12 square feet or less; or

(C) The sign was manufactured before the 12/13/2001 change in administrative rules regarding exempt signs, and the sign continues to comply with those former rules.

(b) Variance for time. The Department may grant a variance for time up to a total of 120 continuous days in a calendar year. The Department may grant the variance for good cause shown. Good cause may include, but is not limited to, a showing that:

(A) The applicant is attempting to obtain an outdoor advertising sign permit for the sign but will be unable to complete the application process within 60 days;

(B) Due to conditions of the land, weather, or similar reasons beyond requester's control, requester will be unable to remove the sign within 60 days.

(7) Prohibitions and penalties.

(a) Other than official traffic control devices, signs are prohibited in state highway right of way. Accessing a sign or sign site by crossing access-controlled right of way is prohibited. Violations of this rule are subject to ORS 377.725(9) and any other removal or penalty provision under law. Signs in or overhanging state highway right of way may be removed pursuant to ORS 377.650 and OAR 734-060-0060 to 734-060-0070.

(b) Signs outside of right of way are subject to the removal procedures of ORS 377.775, and the penalty provisions of ORS 377.992 as well as any other penalty provision under law.

(c) If the sign or site has been accessed from access-controlled right of way, or the sign has been placed in or overhanging right of way, the Department may revoke any variance for that sign, by that requester, or by the represented organization. The Department may deny any subsequent variance request for that sign, by that requester, or by that organization at any location. If the Department discovers multiple violations of (a) above, it may file for an injunction under ORS 374.415.

(8) Signs erected under this rule are subject to the provisions of ORS 377.720 and to all applicable state and federal requirements.

Stat. Auth.: ORS 184.616, 184.619 & 377.735
Stats. Implemented: ORS 377.735
Hist.: HWY 1-1989, f. & cert. ef. 5-2-89; TO 7-2001, f. & cert. ef. 12-13-01; HWD 1-2009, f. & cert. ef. 2-20-09; HWD 11-2014, f. & cert. ef. 12-19-14; HWD 4-2016, f. & cert. ef. 11-28-16

734-060-0180
Restricted Sign Permits

(1) This rule is enacted under the authority of ORS 377.725(14).

(2) A Restricted Permit may be issued for non-conforming signs that were legally located prior to May 31, 2007, where no compensation has been exchanged for the sign's placement or the message(s) displayed, including signs that were permitted, prior to 2007 as a Business Identification or Directional (BID) signs.

(3) Restricted Permits have no relocation or reconstruction benefits. Signs permitted under a Restricted Permit may be maintained, but may not be reconstructed or relocated,

Stat. Auth.: ORS 184.616, 184.619, 377.735
Stats. Implemented: ORS 377.725
Hist.; HWD 4-2016, f. & cert. ef. 11-28-16

734-060-0190
Digital or LED Variable Message Signs Other than Outdoor Advertising Signs

This rule is enacted pursuant to ORS 377.720(3) and (4) regarding signs other than Outdoor Advertising Signs that utilize digital or LED electronic message or variable message technology and are visible to a state highway.

(1) By statute, all signs visible to state highways are subject to state sign prohibited sign and safety regulations. No signs visible to a state high-

way, other than official traffic control signals or devices, may include moving or rotating parts or lights. Signs may not be made to resemble an official traffic signal or device and they may not have lights that project onto the roadway or impede the sight of traveling motorist.

(2) In interpreting ORS 377.715 and 377.720, signs visible to a state highway, other than official traffic control signals or devices, may not:

(a) Be illuminated by flashing lights or a light that varies in intensity;

(b) Have a display surface that creates the appearance of movement;

(c) May not operate at a brightness level of more than 0.3 foot-candles over ambient light, nor intensity greater than the luminance indicated in the table 1, as measured perpendicular to the face of the billboard at the indicated measurement distance for a designated sign dimension: [Table not included. See ED. NOTE.]

(3) Newly constructed signs visible to a state highway, other than official traffic control signals or devices, must be:

(a) Equipped with a light sensor that automatically adjusts the intensity of the sign illumination according to the amount of ambient light, and;

(b) Designed to freeze the display in one static position, display a full black screen or turn off in the event of a malfunction.

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

Stat. Auth.: ORS 184.616, 184.619, 377.710 & 377.720

Stats. Implemented: ORS 377.720

Hist.: HWD 11-2014, f. & cert. ef. 12-19-14; HWD 4-2016, f. & cert. ef. 11-28-16

734-065-0010

Definitions

(1) Transit shelters are structures erected and maintained at official stops for a mass transit district, transportation district or any other public transportation agency to protect their riders from the weather at transit stops, and will hereinafter be referred to as shelters.

(2) Transit Benches are structures erected and maintained at official stops for a mass transit district, transportation district or any other public transportation agency to provide seating at transit stops, and will hereinafter be referred to as benches.

Stat. Auth.: ORS 184.616, 184.619, 377.729

Stat. Implemented: ORS 377.725

Hist.: 2 HD 19-1981, f. & ef. 11-24-81; HWD 9-2009, f. & cert. ef. 11-17-09; HWD 4-2016, f. & cert. ef. 11-28-16

734-065-0015

Construction or Placement of Transit Benches or Shelters

These rules do not grant any authority to construct or place any benches or shelters, nor to maintain any existing benches or shelters, but pertain solely to the placement of outdoor advertising signs on benches or shelters visible from a state highway. New permits for an outdoor advertising sign to be utilized on a transit bench or shelter, may only be issued after the placement of the bench or shelter has been approved by the local jurisdiction having authority, and after the transit sign permit has been obtained from the Department of Transportation.

Stat. Auth.: ORS 184.616, 184.619, 377.753

Stat. Implemented: ORS 377.725; 377.753

Hist.: 2 HD 19-1981, f. & ef. 11-24-81; HWD 9-2009, f. & cert. ef. 11-17-09; HWD 6-2012, f. & cert. ef. 3-26-12; HWD 4-2016, f. & cert. ef. 11-28-16

734-065-0020

Sign Location

(1) Bench and Shelter signs are prohibited on state highway right-of-way.

(2) Bench and Shelter signs are prohibited where visible from an interstate highway or a full access control highway.

(3) Bench and Shelter signs are prohibited in a designated scenic area. No new shelter signs are allowed in a scenic byway.

(4) The bench or shelter on which a sign is placed must be located within a commercial or industrial zone or, if in unzoned city street right-of-way, only where such right of way is adjacent to a commercial or industrial zone.

(5) Bench or shelter may have no more than one sign visible from each direction of travel of the highway.

(6) Bench or shelter signs may only be located at a bus or transit stop on an official city or urban transit system route. The applicant must provide official documentation, such as a route map produced by the transit system, showing that the site meets this requirement.

Stat. Auth.: ORS 184.616, 184.619, 377.729

Stat. Implemented: ORS 377.725

Hist.: 2 HD 19-1981, f. & ef. 11-24-81; HWY 5-1993(Temp), f. & cert. ef. 7-23-93; HWY 6-1993, f. & cert. ef. 10-21-93; HWD 9-2009, f. & cert. ef. 11-17-09; HWD 6-2012, f. & cert. ef. 3-26-12; HWD 4-2016, f. & cert. ef. 11-28-16

734-065-0025

Size and Construction of Sign

(1) Shelters:

(a) The maximum allowable size of a shelter sign is 24 square feet for each side of the sign.

(b) The maximum distance between advertising panels placed back-to-back is one foot.

(c) The sign must not extend beyond the outer edges of the shelter.

(2) Benches:

(a) The maximum allowable size of a bench sign is 16 square feet and the sign shall not exceed two feet in height or eight feet in length excluding supports.

(b) The maximum allowable height is four feet including supports.

Stat. Auth.: ORS 184.616, 184.619, 377.729

Stat. Implemented: ORS 377.725

Hist.: 2 HD 19-1981, f. & ef. 11-24-81; HWD 9-2009, f. & cert. ef. 11-17-09; HWD 6-2012, f. & cert. ef. 3-26-12; HWD 4-2016, f. & cert. ef. 11-28-16

734-065-0035

Spacing

(1) The minimum spacing between signs is as follows:

(a) Within the corporate boundaries of a city, 100 feet from any outdoor advertising sign located on the same side of the highway.

(b) Outside the corporate boundaries of a city, 500 feet from any outdoor advertising sign located on the same side of the highway.

(c) Transit bench signs may only be located inside incorporated city limits or within an urban growth boundary.

(2) If the state highway is routed over a city street as provided in ORS 373.020, a shelter sign may be located on that portion of the city street right-of-way, if approved by the local jurisdiction, outside of the curb; or, if there is no curb, outside of that portion of the right-of-way utilized for state highway purposes.

Stat. Auth.: ORS 184.616, 184.619, 377.729

Stat. Implemented: ORS 377.725

Hist.: 2 HD 19-1981, f. & ef. 11-24-81; HWD 9-2009, f. & cert. ef. 11-17-09; HWD 4-2016, f. & cert. ef. 11-28-16

734-065-0040

Compliance

(1) All signs subject to these rules are also subject to the provisions of ORS 377.700 to 377.840 and to all applicable federal laws, regulations and agreements entered into by the Transportation Commission and the Federal Highway Administration.

(2) All signs erected under these regulations are also subject to any city or county ordinance or regulation.

Stat. Auth.: ORS 184.616, 184.619, 377.729

Stat. Implemented: ORS 377.725

Hist.: 2 HD 19-1981, f. & ef. 11-24-81; HWD 9-2009, f. & cert. ef. 11-17-09; HWD 4-2016, f. & cert. ef. 11-28-16

734-065-0045

Size Variance for Transit

Size variances are not issued for transit bench signs. Upon written request and for good cause shown the Department of Transportation may grant a variance from the size restrictions of OAR 734-065-0025(1) for transit shelter signs not to exceed:

(1) A 32 square foot sign on one side;

(2) A total of 64 square feet of sign face on a back-to-back (32 square foot sign face on each side).

Stat. Auth.: ORS 184.616, 184.619, 377.729

Stat. Implemented: ORS 377.725

Hist.: 2 HD 19-1981, f. & ef. 11-24-81; HWD 9-2009, f. & cert. ef. 11-17-09; HWD 4-2016, f. & cert. ef. 11-28-16

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Oregon Government Ethics Commission
Chapter 199

Rule Caption: Changes number of commissioners for a quorum and to remove chair or vice-chair

Adm. Order No.: GEC 3-2016

Filed with Sec. of State: 11-17-2016

Certified to be Effective: 11-17-16

Notice Publication Date: 10-1-2016

Rules Amended: 199-001-0010

Subject: Changes number of commissioners required for quorum and to remove chair/vice-chair from four to five based on statutory change in total number of commissioners from seven to nine.

Rules Coordinator: Marie Scheffers—(503) 378-5105

199-001-0010
Commission Meetings

(1) Definitions:

(a) "Commission" means Oregon Government Ethics Commission;

(b) "Commissioner" means a duly appointed member of the Oregon Government Ethics Commission;

(c) "Director" means the Executive Director appointed by the Commission pursuant to ORS 244.310 or a person designated by the Executive Director to carry out specific tasks;

(d) "Public Official" means any person who, when an alleged violation of this chapter occurs, is serving the State of Oregon or any of its political subdivisions or any other public body of the state as an officer, employee or agent, irrespective of whether the person is compensated for such services;

(e) "Staff" means the Executive Director and all other persons employed by the Commission.

(2) The Commission shall be governed by the statutes of the State of Oregon, these rules and the Attorney General's Model Rules of Procedure for the conduct of contested cases as provided in ORS Chapter 183. In event of a conflict, precedence shall be in that order.

(3) The Commission has adopted the following rules of procedure:

(a) A quorum consists of five Commissioners. No decision may be made without an affirmative vote of five members. In the absence of a quorum, Commissioners present may meet to discuss any matter before the Commission, but no action shall be taken.

(b) The Commission shall vote by roll call vote on any action taken to initiate or conclude preliminary review or investigative phases, adopt any final order, or adopt an advisory opinion.

(c) The Commission may utilize a consent calendar for action on agenda items when appropriate. In preparation of the consent calendar, the Director shall group together as separate categories preliminary reviews, dismissal of a case at conclusion of investigation, stipulated final orders, and default final orders on the agenda. The Director shall also submit a recommended action for each item. Any Commissioner may request of the chair to have a matter removed from the consent calendar and considered separately. All consent calendar items not removed as such, shall be disposed of upon the motion of any Commissioner and a roll call vote.

(d) The Commission will use the following processes in making decisions:

(A) Consensus to approve meeting minutes;

(B) Voice vote of a quorum of Commissioners in all other matters.

(e) A motion does not require a second.

(f) Annually, at the last regular meeting of the Commission before January 1, the Commission shall select from its members a Chair and a Vice-Chair who shall serve until their successors are selected and qualified. The Chair or Vice-Chair may resign as such or may be removed from that position by vote of five Commissioners. If the Chair or Vice-Chair shall cease to be a Commissioner, the position shall be vacant and a successor shall be selected at the next regular meeting of the Commission.

(g) The Chair shall preside over all meetings of the Commission. Except for final orders and advisory opinions, the Director may execute all documents that are executed in the name of the Commission. Only the Chair shall execute final orders and advisory opinions in the name of the Commission.

(h) The Vice-Chair shall act in lieu of the Chair when the Chair is unable to perform the duties of the office of Chair or while the office is vacant.

(i) The Director shall serve as Secretary to the Commission.

(j) Where permitted by law and conforming to the requirement of the Public Meetings Law, ORS 192.670, the Commission may meet by means of a telephone conference.

(k) The Director, in consultation with the Chair, shall set the agenda and cause all notices of time and place of the meeting of the Commission to be given. Commissioners may request items to be placed on the agenda prior to its being distributed.

(l) All meetings of the Commission shall be open to the public unless otherwise permitted or required by statute.

(m) The agenda of meetings of the Commission shall set forth all matters expected to come before the Commission. The Agenda shall contain items in the following order:

(A) Minutes of previous meetings;

(B) A consent calendar composed of reports of investigation with dismissal recommended by staff, stipulated final orders and final orders by default;

(C) Adoption of contested case final orders, including those which impose a civil penalty or financial forfeiture;

(D) Reports of investigation with preliminary finding of violation recommended by staff;

(E) Adopt advisory opinions pursuant to ORS 171.776 and 244.280;

(F) Presentation of correspondence, publications, or any issue introduced by the Chair related to the Commission and its duties.

(n) Exercising the authority provided by ORS 192.660 and 244.260, the Commission may meet in executive session.

(o) In action on any agenda item, the Commission may dismiss any proceeding or rescind any motion.

(p) The Chair shall be responsible for order and decorum at all meetings of the Commission.

(q) The Chair may suspend or bar from further participation any person who engages in conduct which intentionally delays or disrupts commission proceedings.

(r) Parties may appear in person or be represented by attorneys who are active members of the Oregon State Bar. Others may appear before the Commission on behalf of a party with the permission of the Chair.

(s) The Chair may, at the Chair's discretion, change the order of an agenda in order to accommodate parties appearing before the Commission or for other cause shown.

(t) Commissioners will be advised in writing by the Director or staff of the issues, perceived facts, and arguments during the preliminary review phase. An oral statement from the public official or other respondent will be permitted at the discretion of the Chair when the Commissioners are considering any matter during this phase. The Chair will determine the duration of any oral statement permitted.

(u) Oral statements by the affected public official or any other respondent, their representative or Staff may be permitted by the Chair at any consideration of a motion to move to a contested case, approval of a stipulated disposition of a matter or the adoption of any final order.

(v) The Director shall maintain complete files of all documents submitted in any matter and shall summarize for the Commissioners in an impartial and objective manner all relevant favorable and unfavorable material collected and all documents filed in the Commission's office on any matter before the Commission. At the request of any respondent or complainant any written material submitted to the Director in a timely manner will be reviewed and if the Director determines the information is relevant the material may be provided to each Commissioner for consideration. A document shall be considered filed in a timely manner if submitted in a form permitting it to be copied no less than eight business days before any meeting of the Commission in which the subject matter of the document will be an item on the agenda.

(w) Ex-parte communications with Commissioners by persons other than the staff are not permitted. Documents must be submitted to the Commission through the Director. Oral and written communications to Commissioners concerning matters pending before the Commission other than during the course of formal Commission proceedings, are ex-parte communications.

(x) A subpoena authorized by ORS 244.260(6)(b) may be issued by the Chair, Vice-Chair, or Director:

(A) The subpoena may require the witness to testify to an inquiry which is not privileged and which is relevant to an investigation or inquiry of the Commission including the existence, description, nature, custody, condition, and location of any books, documents, or other tangible things, and the identity and location of persons having knowledge of any discoverable matter. It is not grounds for objection that the information sought will be inadmissible at a hearing pursuant to ORS 183.413 et seq. if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

(B) Upon motion by the witness subpoenaed, or the person under investigation or inquiry, and for good cause shown, the Commission may make any order that justice requires to protect a party or person from annoyance, embarrassment, oppression or undue burden or expense, including one or more of the following:

(i) That the inquiry not be had;

(ii) That the inquiry may be had only on specified terms and conditions, including a designation of the time or place;

(iii) That certain matters not be inquired into, or that the scope of the inquiry be limited to certain matters;

(iv) That the inquiry be conducted with no one present except persons designated by the Commission; or

(v) That a trade secret or other confidential research, development, or commercial information not be disclosed or be disclosed only in a designated way.

(C) A motion for a protective order under this subsection shall be in writing filed with the Director and shall be heard and first decided by the Chair, or in the absence of the Chair, the Vice-Chair, within three business days of the date filed. If the motion for a protective order is denied in whole or in part by the Chair or Vice-Chair, the person making the motion may within three business days thereafter request that the full Commission hear and decide the motion which shall occur within three business days. If the full Commission denies the motion, the party making the motion may within three business days request a contested case hearing pursuant to ORS 183.413 et seq.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 244.290
Stats. Implemented: ORS 244.250, 244.260, 244.290 & 244.310
Hist.: EC 1-1993, f. & cert. ef. 4-22-93; GSPC 1-1999, f. 7-29-99, cert. ef. 8-1-99; GEC 1-2010, f. 3-12-10, cert. ef. 3-15-10; GEC 1-2016, f. & cert. ef. 6-1-16; GEC 3-2016, f. & cert. ef. 11-17-16

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Rule Caption: Regarding policies specifying when a public official may directly supervise a relative under ORS 244.179
Adm. Order No.: GEC 4-2016
Filed with Sec. of State: 11-17-2016
Certified to be Effective: 11-17-16
Notice Publication Date: 10-1-2016
Rules Adopted: 199-005-0080
Subject: Provides guidance to public bodies in creating and adopting a policy that specifies when a public official acting in an official capacity may directly supervise a person who is a relative or member of the household of the public official.
Rules Coordinator: Marie Scheffers—(503) 378-5105

199-005-0080
Policy Specifying when a Public Official acting in an Official Capacity may Directly Supervise a Relative or Member of Household under ORS 244.179

(1) The purpose of this rule is to provide guidance to a public body in creating and adopting a policy that specifies when a public official acting in an official capacity may directly supervise a person who is a relative or member of the household of the public official.

(2) A policy that specifies when a public official acting in an official capacity may directly supervise a relative shall be in writing and shall be formally adopted by the public body that the public official serves.

(3) A policy that specifies when a public official acting in an official capacity may directly supervise a relative shall comply with the other provisions of ORS Chapter 244. Any such policy shall provide for delegation to another person of any task that would constitute a prohibited use of office for financial gain pursuant to ORS 244.040(1) or a conflict of interest pursuant to ORS 244.120. The policy shall provide a method that complies with ORS 244.120 for the supervising public official to handle conflicts of interest when called upon to take actions or make decisions or recommendations regarding the financial interests of the relative or member of household who is being supervised. Examples of tasks that might constitute prohibited use of office or a conflict of interest if performed by a public official for a relative or member of household who the public official was supervising may include:

(a) Performing or approving an annual review or performance evaluation

(b) Signing a paycheck for a relative or member of household

(c) Signing a personnel action form providing for a change in salary or benefits for the relative or member of household

(d) Assigning shifts where there is discretion as to number of hours, differential pay rates, locations or overtime

(e) Approving overtime or expenses

(4) Nothing in this rule shall be construed to allow a public official to perform any of the tasks prohibited by ORS 244.177 regarding employing a relative or member of household. ORS 244.177(1)(a) prohibits a public official, except as otherwise provided, from appointing, employing or promoting a relative or member of the household to, or discharging, firing, or demoting a relative or member of the household from, a position with the public body that the public official serves or over which the public official exercises jurisdiction or control, unless the public official complies with the conflict of interest requirements of ORS Chapter 244. ORS 244.177(1)(b) prohibits a public official from participating as a public official in any interview, discussion or debate regarding the appointment, employment or promotion of a relative or member of the household to, or the discharge, firing or demotion of a relative or member of the household from, a position with the public body that the public official serves or over which the public official exercises jurisdiction or control. For further definitions and exceptions, see ORS 244.177.

Stat. Auth.: ORS 244.290
Stat. Implemented: ORS 244.179
Hist.: GEC 4-2016, f. & cert. ef. 11-17-16

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Rule Caption: Adopts rule concerning executive session held under ORS 192.660(2)(a) to consider employment
Adm. Order No.: GEC 5-2016
Filed with Sec. of State: 11-17-2016
Certified to be Effective: 11-17-16
Notice Publication Date: 10-1-2016
Rules Adopted: 199-040-0027
Subject: Rule 199-040-0027 provides guidance to governing bodies that intend to hold an executive session to consider the employment of a public officer, employee, staff member or individual agent under ORS 192.660(2)(a).
Rules Coordinator: Marie Scheffers—(503) 378-5105

199-040-0027
Employment of a Public Officer, Employee, Staff Member or Individual Agent

(1) The purpose of this rule is to provide guidance to a governing body when the governing body holds an executive session permitted by ORS 192.660(2)(a): "To consider the employment of a public officer, employee, staff member or individual agent."

(2) In order to meet the requirements for an executive session permitted by ORS 192.660(2)(a), the individual agent whose employment the governing body is considering must be a single person. Some examples may include a city attorney, an accountant or another individual who would perform services on behalf of the public body in the capacity of an agent, even if the prospective individual agent works for a larger firm or company. A firm or business entity that consists of more than one person is not an individual agent, and a governing body shall not consider the employment of a firm or entity in executive session under this section.

(3) When a governing body convenes an executive session to consider employment of a public officer, employee or staff member under ORS 192.660(2)(a), the governing body must first fulfill the prerequisites listed in ORS 192.660(7)(d). ORS 192.660(7)(d) requires that the public body:

(a) Advertise the vacancy;

(b) Adopt regular hiring procedures;

(c) In the case of an officer, offer the public an opportunity to comment on the employment of the officer; and

(d) In the case of a chief executive officer, the governing body must have adopted hiring standards, criteria and policy directives in meetings open to the public in which the public has had the opportunity to comment on the standards, criteria and policy directives.

(4) When a governing body convenes an executive session to consider the employment of an individual agent under ORS 192.660(2)(a), it is not required to fulfill the prerequisites listed in ORS 192.660(7)(d).

Stat. Auth.: ORS 244.290
Stat. Implemented: ORS 192.660(2)(a), 192.660(7)(d)
Hist.: GEC 5-2016, f. & cert. ef. 11-17-16

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Oregon Health Authority, Health Licensing Office, Behavior Analysis Regulatory Board Chapter 824

Rule Caption: Senate Bill 696 changed Behavior Analysis Regulatory Board and who the Board licenses and registers.
Adm. Order No.: BARB 1-2016
Filed with Sec. of State: 11-22-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 10-1-2016
Rules Adopted: 824-036-0001, 824-070-0005, 824-070-0010
Rules Amended: 824-010-0005, 824-030-0010, 824-030-0040, 824-040-0010, 824-050-0010, 824-060-0010
Rules Repealed: 824-035-0005
Subject: Senate Bill 696 changed the Behavior Analysis Regulatory Board and who the board licenses and registers. It directed the

board to adopt rules to license behavior analysts and assistant behavior analysts and create a pathway to license a "grandfathered" group of practitioners. It directed the Health Licensing Office to establish rules for registration of behavior analysis interventionists. These rules amend those established under ORS 676.800 to meet the requirements of SB 696.

Rules Coordinator: Samantha Patnode—(503) 373-1917

824-010-0005
Definitions

(1) "Accredited college or university" means a college or university as listed in the Council on Higher Education database, or evaluated through the National Association of Credential Evaluations Services or World Education Services for equivalency.

(2) "Affidavit of Licensure" has the meaning set forth in OAR 331-030-0040.

(3) "Applied behavior analysis" has the definition set forth in ORS 676.802.

(4) "Authorization" has the definition set forth in ORS 676.580.

(5) "Autism spectrum disorder" has the definition set forth in Oregon Laws 2013, chapter 771 section 2(1)(B)(b): the meaning given that term in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association.

(6) "BACB" means the Behavior Analyst Certification Board.

(7) "BCBA" means a Board Certified Behavior Analyst.

(8) "BCaBA" means a Board Certified Assistant Behavior Analyst.

(9) "Board" means the Behavior Analysis Regulatory Board.

(10) "Declarant" means an individual who submitted a Declaration of Active Practice to the HLO pursuant to Oregon Laws 2013, chapter 771, section 4. For ease of reference, the note under ORS 676.806 (2015) quotes Oregon Laws 2013, chapter 771, section 4.

(11) "Direct supervision" means the training or the observation of an interventionist or a declarant providing client services and at a minimum requires the participation of the supervisor, the interventionist or declarant and client. Participation can include remote supervision through Health Insurance Portability and Accountability Act-compliant technology, as long as it is synchronous audio and visual, and in real time.

(12) "Indirect supervision" means supervisory functions including: training the interventionist or declarant without the client present, consulting with families or caregivers regarding interventionist or declarant service delivery, or completing evaluations or assessments of an interventionist or declarant without the client present.

(13) "Interventionist" means a Behavior Analysis Interventionist.

(14) "Licensed health care professional" has the definition set forth in ORS 676.802(2).

(15) "Office" means the Health Licensing Office.

(15) "Official transcript" means an original document certified by an accredited college or university indicating hours and types of course work, examinations and scores that the student has completed. The accredited college or university must submit the transcript by mail or courier directly to the Office in a sealed envelope.

(16) "Ongoing supervision and training" means a supervisor is monitoring the service delivery of an interventionist by direct and indirect means.

Stat. Auth.: ORS 676.800
Stats. Implemented: ORS 676.800
Hist.: BARB 1-2014, f. 10-21-14, cert. ef. 12-1-14; BARB 1-2015, f. 10-30-15, cert. ef. 11-1-15; BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

824-030-0010
Licensing of Behavior Analyst

An individual applying for licensure as a Behavior Analyst must:

(1) Submit a completed application form, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application fees.

(2) Arrange for proof of current certification by the Behavior Analyst Certification Board, Incorporated, as a Board Certified Behavior Analyst or equivalent to be sent from the BACB to the Office;

(3) Pass a fingerprint-based nationwide criminal records check pursuant to OAR 331-030-0004.

(4) If applicable, submit an affidavit of licensure from any state where the individual holds or has held a license as a behavior analyst whether the license is active or inactive.

(5) Submit required license fees.

Stat. Auth.: ORS 676.800
Stats. Implemented: ORS 676.800
Hist.: BARB 1-2014, f. 10-21-14, cert. ef. 12-1-14; BARB 1-2015, f. 10-30-15, cert. ef. 11-1-15; BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

824-030-0040
Registration of a Behavior Analysis Interventionist

An individual applying for registration as a Behavior Analysis Interventionist must:

(1) Submit a completed application form, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application fees;

(2) Submit required registration fees.

(3) Submit proof of being at least 18 years old;

(4) Submit documentation of a high school diploma or General Educational Development (GED) certificate;

(5) Pass a fingerprint-based nationwide criminal records check pursuant to OAR 331-030-0004; and

(6) Submit documentation of 40 hours of professional training in applied behavior analysis on a form prescribed by the Office in the following knowledge and skill areas, as verified by an individual listed in ORS 676.802 2)(a-h) or licensed by the Board:

(a) Professional and ethical issues;

(b) Foundational knowledge of behavioral change principles;

(c) Assessment;

(d) Implementation of prescribed intervention plans;

(e) Data collection and documentation.

Stat. Auth.: ORS 676.800
Stats. Implemented: ORS 676.800
Hist.: BARB 1-2014, f. 10-21-14, cert. ef. 12-1-14; BARB 1-2015, f. 10-30-15, cert. ef. 11-1-15; BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

824-036-0001
Requirements for licensure

An individual applying for licensure as a Behavior Analyst through the grandfathering path must:

(1) Have submitted a declaration of practice to the Office on or before April 30, 2016.

(2) Submit a completed application form, which must contain the information listed in OAR 331-030-0000;

(3) Submit required licensing fees.

(4) Submit proof of having at least a master's degree in:

(a) Education,

(b) Psychology, or

(c) Applied behavior analysis; and

(5) Submit proof of 10 years of full-time experience in applied behavior analysis as defined in ORS 676.802 (1)(a); this must include a letter that describes the declarant's experience and competencies in measurement, experimental design, behavior change procedures, principles of applied behavior analysis, identification of presenting issues, case management, supervision, assessment and intervention; and

(6) Submit three letters of recommendation – none can be from a Board or family member — that attest to the applicant's practice in applied behavior analysis as defined in ORS 676.802 (1)(a), with observation and client progress report review. For the purposes of this rule, a family member is related by birth, marriage, adoption or domestic partnership; two must be from a BCBA; no more than one can be from a licensed health-care professional defined in ORS 676.802 (2); no more than one letter can come from a person in the declarant's practice or a current client or client's family; and

(7) Submit official transcripts showing proof of having completed 270 classroom hours in applied behavior analysis as defined in ORS 676.802 (1)(a), including 45 hours in ethics and professional conduct as related to behavior analysis, 45 hours in principles of behavior analysis as defined in ORS 676.802 (1)(a), 45 hours in behavior analytic research methods and analysis, 105 hours in applied behavior analysis, and 30 discretionary hours; if the courses were completed more than 10 years ago, submit proof of having completed 50 hours of continuing education in applied behavior analysis, 12 of which must be in ethics related to applied behavior analysis as defined in ORS 676.802 (1)(a) that were acquired within three calendar years prior to the date of application; and

(8) Submit proof of having completed 1,500 hours of supervised experience, of which 75 hours must be direct supervision, in applied behavior analysis as defined in ORS 676.802 (1)(a), or have 75 hours of direct supervision with a BCBA who signs off on the applicant's competency to practice applied behavior analysis as defined in ORS 676.802 (1)(a); and

(9) Pass a fingerprint-based, nationwide criminal records check pursuant to OAR 331-030-0004.

Stat. Auth.: ORS 676.802 - 676.830

Stats. Implemented: ORS 676.802 - 676.830
Hist.: BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

824-040-0010
Training and Supervision

(1) Prior to the Registered Behavior Analysis Interventionist providing any independent service delivery to clients, the interventionist must:

(a) Enter into an agreement with each supervisor using the form available on the Office's website. A copy of the agreement must be submitted to the Office and given to the client's parent or guardian.

(b) Complete the competency assessment with one of the supervisors on the form available on the Office's website, or on another competency form with the same information. A copy of the competency assessment must be retained in the interventionist's file.

(2) After beginning independent client service delivery, a Registered Behavior Analysis Interventionist must receive ongoing training and supervision by a licensed behavior analyst, licensed assistant behavior analyst or by a licensed health care professional as defined in ORS 676.802(2), consisting of:

(a) A combination of direct and indirect supervision for at least 5 percent of the interventionist's service hours;

(b) Direct supervision at least once per calendar month in the months when services were provided.

(3) A Registered Behavior Analysis Interventionist must be evaluated by one of the supervisors at least once a year, after the initial competency assessment, on the form available on the Office's website or on another evaluation form with the same information.

(4) A Registered Behavior Analysis Interventionist must maintain a log of ongoing training and supervision on the form available on the Office's website, or on the supervisor's form that contains all the same information.

(5) A Registered Behavior Analysis Interventionist must notify the Office in writing within 10 business days if the interventionist is no longer being supervised, or has a change in supervision.

(6) A Registered Behavior Analysis Interventionist must maintain all training and supervision records for a minimum of five years after the last day of training and supervision and must make records available for inspection by the Office.

Stat. Auth.: ORS 676.800
Stats. Implemented: ORS 676.800
Hist.: BARB 1-2014, f. 10-21-14, cert. ef. 12-1-14; BARB 1-2015, f. 10-30-15, cert. ef. 11-1-15: BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

824-050-0010
Renewal of License and Registration

(1) An authorization is subject to the provisions of OAR chapter 331 division 30 regarding the renewal of an authorization, and provisions regarding the use of the title, identification and requirements for issuance of a duplicate authorization.

(2) Authorization renewal under this rule is valid for one year.

(3) Authorization holders must pass a state criminal background check pursuant to OAR 331-030-0004;

(4) To avoid late fees, an authorization renewal must be made prior to the authorization entering inactive status. The authorization holder must submit the following:

(a) Renewal application form;

(b) Payment of renewal fee pursuant to OAR 824-020-0040;

(5) Inactive authorization renewal: An authorization holder in inactive status cannot use the title. An authorization may be inactive for up to three years. When renewing, the inactive authorization holder must submit:

(a) Renewal application form;

(b) Payment of late and renewal fees pursuant to OAR 824-020-0040;

(6) An authorization that has been inactive for more than three years is expired and the authorization holder must reapply for authorization and meet the requirements listed in OAR 824-030-0010, 824-030-0020 or 824-030-0040.

Stat. Auth.: ORS 676.800
Stats. Implemented: ORS 676.800
Hist.: BARB 1-2014, f. 10-21-14, cert. ef. 12-1-14; BARB 1-2015, f. 10-30-15, cert. ef. 11-1-15: BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

824-060-0010
Standards of Practice, Professional Methods and Procedures

(1) In Oregon, the statutory definition of applied behavior analysis is stated in 676.802 (1)(a)-(b).

(2) For both behavior analysts and assistant behavior analysts, the Board adopts sections 1-9 of the 2016 "BACB Professional and Ethical Compliance Code for Behavior Analysts."

Stat. Auth.: ORS 676.800
Stats. Implemented: ORS 676.800
Hist.: BARB 1-2014, f. 10-21-14, cert. ef. 12-1-14: BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

824-070-0005
Continuing Education Requirements

(1) For purposes of this rule and 824-070-0010, the licensure year begins on the day of the month that the licensee was originally licensed and extends for the following 364 days.

(2) To maintain licensure, a behavior analyst must complete a minimum of 16 hours of continuing education every licensure year. At least one hour of continuing education must relate to ethics in applied behavior analysis as defined in ORS 676.802(1).

(3) To maintain licensure, an assistant behavior analyst must complete a minimum of 10 hours of continuing education every licensure year. At least one hour of continuing education must relate to ethics in applied behavior analysis as defined in ORS 676.802(1).

(4) A licensee must document compliance with the continuing education requirement through attestation on the license renewal application. A licensee is subject to provisions of OAR 824-070-0010 pertaining to periodic audit of continuing education.

(5) Continuing education must be obtained by participation in or attendance at a course provided by an institution of higher education accredited by the Northwest Association of Accredited Schools, the Northwest Commission on Colleges and Universities, or the State Board of Higher Education; or a course or program approved by the Behavior Analysis Regulatory Board, or other professional organizations or associations that conduct educational meetings, workshops, symposiums, and seminars where CEU credit is offered and where the subject matter meets the requirements under subsection (6) of this rule.

(6) Continuing education must address subject matter related specifically to applied behavior analysis as set forth in ORS 676.802(1)(a), the rules regulating licensed behavior analysts and assistant behavior analysts, or related applied behavior analysis practices, ethics, or business practices.

(7) Continuing education may include teaching a course sponsored by a CE provider listed in subsection (5) of this rule where the subject matter meets the requirements under subsection (6) of this rule. No more than half of the required hours shall be from teaching).

(8) Proof of participation in required continuing education is the responsibility of the licensee.

(9) The licensee must maintain documentation of compliance with continuing education requirements for a period of two years following renewal, and must make the documentation available to HLO upon request.

(10) A licensee may carry up to 10 continuing education hours forward to the next renewal cycle.

(11) For the purpose of this rule, continuing education hours mean actual academic, classroom, or course work time, including but not limited to workshops, symposiums, or seminars. Continuing education hours do not include travel time to or from the training site, registration or check-in periods, breaks or lunch periods.

Stat. Auth.: ORS 676.802 - 676.830
Stats. Implemented: ORS 676.802 - 676.830
Hist.: BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

824-070-0010
Continuing Education Audit, Required Documentation and Sanctions

(1) The Office will audit 10 percent of licensees, to verify compliance with continuing education requirements.

(2) Licensees who are selected for audit must submit satisfactory evidence of participation in required continuing education within 30 days of the audit notice.

(3) If selected for audit, the licensee must provide documentation from sources listed in 824-070-0005(5).

(4) If documentation of continuing education is incomplete, the licensee has 30 days from the date of notice to submit further documentation to substantiate having completed the required continuing education.

(5) Failure to meet continuing education requirements shall constitute grounds for disciplinary action, which may include, but is not limited to, assessment of a civil penalty and suspension or revocation of the license.

Stat. Auth.: ORS 676.802 - 676.830
Stats. Implemented: ORS 676.802 - 676.830
Hist.: BARB 1-2016, f. 11-22-16, cert. ef. 1-1-17

Oregon Health Authority,
Health Systems Division: Addiction Services
Chapter 415

Rule Caption: Permanent amendments to OAR 415-055 regarding restricted license for driving under the influence of intoxicants.
Adm. Order No.: ADS 7-2016
Filed with Sec. of State: 12-5-2016
Certified to be Effective: 12-5-16
Notice Publication Date: 10-1-2016
Rules Amended: 415-055-0000, 415-055-0010, 415-055-0035
Subject: The purpose of these rules is to prescribe service delivery standards and procedures for approval of outpatient alcoholism and drug-dependence treatment programs which make recommendations to the Division of Motor Vehicles (DMV) regarding persons seeking a restricted operator's license.
Rules Coordinator: Nola Russell—(503) 945-7652

415-055-0000
Purpose

The purpose of these rules is to prescribe service delivery standards and procedures for approval of outpatient alcoholism and drug-dependence treatment programs which make recommendations to the Division of Motor Vehicles (DMV) regarding persons seeking a restricted operator's license.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0000; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 5-2016(Temp), f. & cert. ef. 8-10-16 thru 2-5-17; ADS 7-2016, f. & cert. ef. 12-5-16

415-055-0010
Application for Program Approval

New programs seeking Division approval to make recommendations to DMV regarding restricted driving licenses shall:

(1) Comply with applicable rules and procedures including OAR 309-008-0100 to 309-008-1600 and 415-051-0000 through 415-051-0150;

(2) Be currently holding a Certificate issued pursuant to OAR 309-008-0100 to 309-008-1600 by the Division for DUII Rehabilitation Program: and

(3) Have maintained a DUII Rehabilitation Program Certification from the Division for four continuous years prior to making application.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0010; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 5-2016(Temp), f. & cert. ef. 8-10-16 thru 2-5-17; ADS 7-2016, f. & cert. ef. 12-5-16

415-055-0035
Variances

Requirements and standards for requesting and granting variances or exceptions are found in OAR 309-008-1600.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0035; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 5-2016(Temp), f. & cert. ef. 8-10-16 thru 2-5-17; ADS 7-2016, f. & cert. ef. 12-5-16

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Rule Caption: Permanent amendments to OAR 415-012 titled "Licensure of Alcohol and Other Drug Abuse Treatment Programs".
Adm. Order No.: ADS 8-2016
Filed with Sec. of State: 12-14-2016
Certified to be Effective: 12-14-16
Notice Publication Date: 10-1-2016
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, 415-012-0090
Subject: 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; or

(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.
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 (CCO), 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; ADS 8-2016, f. & cert. ef. 12-14-16

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 obliga-

tions between a county or other government organization and the Division for the purpose of operating an alcohol and drug use disorder service.

(9) "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.

(10) "Licensed Child Care Facility" means a facility licensed under ORS 657A.280.

(11) "Non-Funded Provider" means an organization not contractually affiliated with the Division, a CMHP, or other contractor of the Division.

(12) "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.

(13) "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.

(14) "Quality Assurance" means the process of objectively and systematically monitoring and evaluating the quality and appropriateness of care to identify and resolve identified problems.

(15) "Restriction" means any limitations placed on a license such as age of individuals to be served or number of individuals to be served.

(16 "Revocation" means the removal of authority for a provider to provide certain services under a license.

(17) "School Attended Primarily By Minors" means an existing public or private elementary, secondary or career school attended primarily by individuals under age eighteen.

(18) "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.

(19) "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.

(20) "Substantial Failure to Comply" is used in this rule to mean the opposite of "substantial compliance."

(21) "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.

(22) "Temporary" means a LOA license issued for 185 days to a program approved for the first time. A temporary LOA license cannot be extended.

(23) "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; ADS 8-2016, f. & cert. ef. 12-14-16

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; ADS 8-2016, f. & cert. ef. 12-14-16

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; ADS 8-2016, f. & cert. ef. 12-14-16

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; ADS 8-2016, f. & cert. ef. 12-14-16

415-012-0040
Licenses

(1) The Division may issue a residential license under these rules for a duration not to exceed two years.

(2) 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.

(3) 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.

(4) 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.

(5) 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.

(6) 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.

(7) Restriction to Appear on License: The effective date and expiration date of the restriction shall be indicated on the certificate.

(8) 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.

(9) 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.

(10) 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; ADS 8-2016, f. & cert. ef. 12-14-16

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 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 2-2007, 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; ADS 8-2016, f. & cert. ef. 12-14-16

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; ADS 8-2016, f. & cert. ef. 12-14-16

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 alicense 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 a license 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; ADS 8-2016, f. & cert. ef. 12-14-16

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 alicense 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; ADS 8-2016, f. & cert. ef. 12-14-16

415-012-0067
Response to Criminal Records

(1) The Division may deny, refuse to renew, suspend, or revoke a license 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; ADS 8-2016, f. & cert. ef. 12-14-16

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

(c) 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; ADS 8-2016, f. & cert. ef. 12-14-16

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Rule Caption: Permanent amendments to OAR 415-020 titled Outpatient Synthetic Opiate Treatment Programs.
Adm. Order No.: ADS 9-2016
Filed with Sec. of State: 12-14-2016
Certified to be Effective: 12-14-16
Notice Publication Date: 10-1-2016
Rules Amended: 415-020-0000, 415-020-0005, 415-020-0010, 415-020-0090
Subject: These rules prescribe standards for the development and operation of Opiod Treat Programs approved by the Health Systems Division of the Oregon Health Authority.
Rules Coordinator: Nola Russell—(503) 945-7652

415-020-0000
Purpose

These rules prescribe standards for the development and operation of Opioid Treatment Programs approved by the Health Systems Division of the Oregon Health Authority.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 430.010(4)(b) & 430.560 - 430.590
Hist.: HR 4-1988, f. & cert. ef. 5-10-88; HR 17-1993, f. & cert. ef. 7-23-93, Renumbered from 410-006-0000; ADAP 3-1995, f. 12-1-95, cert. ef. 3-1-96; ADS 1-2003, f. 6-13-03, cert.

ef. 7-1-03; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 6-2016(Temp), f. & cert. ef. 8-10-16 thru 2-5-17; ADS 9-2016, f. & cert. ef. 12-14-16

415-020-0005
Definitions

(1) "Accreditation" means the process of review and acceptance by an accreditation body.

(2) "Accreditation Body" means an organization that has been approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) to accredit opioid treatment programs that use opioid agonist treatment medications.

(3) "Accredited Opioid Treatment Program" means a program that is the subject of a current, valid accreditation from an accreditation body approved by SAMHSA.

(4) "Assessment" means the process of obtaining all pertinent biopsychosocial information, through a face-to-face interview and additional information as provided by the individual, family and collateral sources as relevant, to determine a diagnosis and to plan individualized services and supports.

(5) "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.

(6) "Community Mental Health Program (CMHP)" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, 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 Oregon Health Authority.

(7) "Comprehensive maintenance treatment" means opioid agonist medication treatment that includes a broad range of clinically appropriate medical and rehabilitative services.

(8) "Division" means the Health Systems Division of the Oregon Health Authority (OHA).

(9) "Medically Supervised Withdrawal" means the administration of an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug free state.

(10) "Diversion Control Plan" means a plan implemented by the opioid treatment program that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use.

(11) "Employee" means an individual who provides a program service or who takes part in a program service and who receives wages, a salary, or is otherwise paid by the program for providing the service.

(12) "Federal Opioid Treatment Standards" means the standards established by the Secretary of Health and Human Services that are used to determine whether an opioid treatment program is qualified to engage in opioid treatment.

(13) "Interim Maintenance Treatment" means treatment provided in conjunction with appropriate medical services while a patient is awaiting transfer to a program that provides comprehensive maintenance treatment.

(14) "Long-Term Medically Supervised Withdrawal Treatment" means treatment for a period of more than 30 days but not exceeding 180 days.

(15) "Maintenance Treatment" means the administration of an opioid agonist treatment medication at stable dosage levels for a period longer than 21 days.

(16) "Medical Director" means a physician licensed to practice medicine in the State of Oregon who is designated by the opioid treatment program to be responsible for the program's medical services.

(17) "Medical Professional" means a medical or osteopathic physician, physician's assistant licensed by the Board of Medical Examiners, or a registered nurse or nurse practitioner licensed by the Board of Nursing.

(18) "Opiate Addiction" means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opiates despite significant opiate-induced problems. Opiate addiction is characterized by repeated self-administration that usually results in tolerance, withdrawal symptoms, and compulsive drug taking.

(19) "Opioid Agonist Medication" means any drug that is approved by the Food and Drug Administration under Section 505 of Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for use in the treatment of opiate addiction.

(20) "Opioid Treatment Program" means a program that dispenses and administers opioid agonist medications in conjunction with appropriate counseling, supportive, and medical services.

(21) "Patient" means any individual who receives services in an opioid treatment program.

(22) "Patient Record" means the official legal written file for each patient, containing all the information required to demonstrate compliance with these rules. Information in program records maintained in electronic format must be produced in a contemporaneous printed form, authenticated by signature and date of the person who provided the service, and placed in the patient record.

(23) "Program Staff" means:

(a) An employee or person who, by contract with the program, provides a clinical service and who has the credentials required in these rules to provide the clinical service; and

(b) Any other employee of the program.

(24) "Quality Assurance" means the process of objectively and systematically monitoring and evaluating the appropriateness of patient care to identify and resolve identified problems.

(25) "Rehabilitation" means those services, such as vocational rehabilitation or academic education, which assist in overcoming the problems associated with drug abuse or drug dependence and which enable the patient to function at his or her highest potential.

(26) "State Methadone Authority" means the State Methadone Authority designated pursuant to section 409 of Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972, or in lieu thereof, any other State authority designated by the Governor for purposes of exercising the authority under this section. The State Methadone Authority for Oregon is the Addictions and Mental Health Division of the Oregon Health Authority.

(27) "Treatment" means the specific medical and non-medical therapeutic techniques employed to assist the patient in recovering from drug abuse or drug dependence.

(28) "Urinalysis Test" means an analytical procedure to identify the presence or absence of specific drugs or metabolites in a urine specimen.

(29) "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.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 430.010(4)(b) & 430.560 - 430.590
Hist.: HR 4-1988, f. & cert. ef. 5-10-88; HR 17-1993, f. & cert. ef. 7-23-93, Renumbered from 410-006-0005; ADAP 3-1995, f. 12-1-95, cert. ef. 3-1-96; ADS 1-2003, f. 6-13-03, cert. ef. 7-1-03; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 5-2013, f. & cert. ef. 6-7-13; ADS 6-2016(Temp), f. & cert. ef. 8-10-16 thru 2-5-17; ADS 9-2016, f. & cert. ef. 12-14-16

415-020-0010
Program Approval

(1) Letter of Approval: No person or governmental entity shall operate an Opioid Treatment Program without a letter of approval from the State Methadone Authority in Oregon.

(2) Application: To receive a certificate for the provision of behavioral health treatment services an Opioid Treatment Program must meet the criteria under OAR 309-008-0100 to 309-008-1600; in addition, the Opioid Treatment Program must:

(a) Meet the standards set forth in these rules and any other administrative rules applicable to the program;

(b) Comply with the federal regulations contained in 42 CFR Part 2 and 42 CFR Part 8; and

(c) Submit documentation of accreditation as an opioid treatment program by an accreditation body approved by SAMHSA under 42 CFR Part 8.

(d) Specify in the application the identity and financial interest of any person (if the person is a corporation, the name of any stockholder holding stock representing an interest of 5 percent or more) or other legal entity who has an interest of 5 percent or more or 5 percent of a lease agreement for the facility.

(3) Renewal: The renewal of a Certificate shall be governed by OAR 309-008-0100 to 309-008-1600.

(4) Denial, Revocation, Nonrenewal, Suspension: The denial, revocation, nonrenewal, or suspension of a letter of approval or license for an opioid treatment program may be based on any of the grounds set forth in OAR 309-008-1100.

(5) Federal Protocols: The program shall be responsible for filing and maintaining all necessary protocols and documentation required by the National Institute on Drug Abuse (NIDA), the Federal Substance Abuse

and Mental Health Services Administration, and the Federal Drug Enforcement Administration.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 430.010(4)(b), 430.560 - 430.590
Hist.: HR 4-1988, f. & cert. ef. 5-10-88; HR 17-1993, f. & cert. ef. 7-23-93, Renumbered from 410-006-0010; ADAP 3-1995, f. 12-1-95, cert. ef. 3-1-96; ADS 1-2003, f. 6-13-03, cert. ef. 7-1-03; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 6-2016(Temp), f. & cert. ef. 8-10-16 thru 2-5-17; ADS 9-2016, f. & cert. ef. 12-14-16

415-020-0090
Variances

Requirements and standards for requesting and granting variances or exceptions are found in OAR 309-008-1600.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 183, 430.560 & 430.590
Hist.: HR 4-1988, f. & cert. ef. 5-10-88; HR 17-1993, f. & cert. ef. 7-23-93, Renumbered from 410-006-0090; ADAP 3-1995, f. 12-1-95, cert. ef. 3-1-96; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 6-2016(Temp), f. & cert. ef. 8-10-16 thru 2-5-17; ADS 9-2016, f. & cert. ef. 12-14-16

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Rule Caption: Permanent repeals of OAR 415-060 regarding the reduction of tobacco use by minors.
Adm. Order No.: ADS 10-2016
Filed with Sec. of State: 12-14-2016
Certified to be Effective: 12-14-16
Notice Publication Date: 10-1-2016
Rules Repealed: 415-060-0020, 415-060-0010, 415-060-0030, 415-060-0040, 415-060-0050
Subject: These rules adopt procedures concerning random and targeted inspections of outlets that sell tobacco products which require 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: Updating Rate Table Incorporated by Reference
Adm. Order No.: DMAP 64-2016
Filed with Sec. of State: 11-23-2016
Certified to be Effective: 11-29-16
Notice Publication Date: 11-1-2016
Rules Amended: 410-170-0110
Rules Repealed: 410-170-0110(T)
Subject: The Authority needs to amend the date of the Behavioral Rehabilitation Services rate table referenced in 410-170-0110 to reflect new rate changes. The rates table is available at: http://www.oregon.gov/oha/healthplan/tools/Rate%20Table%20-%20May%201,%202016.pdf.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-170-0110
Billing and Payment for Services and Placement Related Activities

(1) The BRS contractor is compensated for a billable care day (service and placement related activities rates) on a fee-for-service basis, except as otherwise provided for in these rules. The Authority does not make payments for any calendar day that does not meet the definition of a billable care day under this rule.

(2) Billable care day rates are provided in the "BRS Rates Table," dated May 1, 2016, which is adopted as Exhibit 1 and incorporated by reference into this rule. The BRS Rates Table is available at http://www.oregon.gov/OHA/healthplan/pages/brs.aspx. A printed copy may be obtained from the agency.

(3) Billable Care Day:

(a) For purposes of computing a billable care day, the BRS client must be in the direct care of the BRS provider at 11:59 p.m. of that day or be on an authorized home visit in accordance with section (4) of this rule;

(b) A billable care day does not include any day where the BRS client is on runaway status, in detention, an inpatient in a hospital, or has not yet entered or has been discharged from the BRS contractor's or BRS provider's program.

(4) Home Visits:

(a) The BRS contractor shall only include a maximum of eight calendar days of home visits in a month as billable care days;

(b) In order to qualify as an authorized home visit day, the BRS contractor must:

(A) Ensure that the home visit is tied to the BRS client's ISP or MSP;

(B) Work with the BRS client and the BRS client's family or substitute family on goals for the home visit and receive regular reports from the family on the BRS client's progress while on the home visit;

(C) Have staff available to answer calls from the BRS client and BRS client's family or substitute family and to provide services to the BRS client during the time planned for the home visit if the need arises;

(D) Document communications with the BRS client's family or substitute family; and

(E) Document the BRS client's progress on goals set for the home visits.

(5) Invoice form:

(a) The BRS contractor must submit a monthly billing form to the agency in a format acceptable to the agency on or after the first day of the month following the month in which it provided services and placement related activities to the BRS client. The billing form must specify the number of billable care days provided to each BRS client in that month;

(b) The BRS contractor must provide, upon request in a format that meets the agency's approval, written documentation of each BRS client's location for each day claimed as a billable care day;

(c) The BRS contractor may only submit a claim for a billable care day consistent with the agency's prior authorization.

(6) Payment for a Billable Care Day:

(a) The agency shall pay the service and placement related activities rates to the BRS contractor for each billable care day in accordance with the BRS Rates Table described in section (2) of this rule;

(b) Notwithstanding section (6)(a) of this rule, the Authority shall only pay the service rate for each billable care day to a public child-caring agency, who by rule or contract provides the local match share for Medicaid claims under OAR 410-120-0035 and 42 CFR 433 Subpart B. The Authority may not pay the placement related activities rate for each billable care day to these types of public child-caring agencies;

(c) To the extent the payment for services is funded by Medicaid and CHIP funds, the BRS contractor and the BRS provider are subject to Medicaid billing and payment requirements in these rules and the Authority's general rules (OAR 410-120-0000 to 410-120-1980).

(7) Third Party Resources:

(a) The Authority's BRS contractors must make reasonable efforts to obtain payment first from other resources consistent with OAR 410-120-1280(16);

(b) The Department's and OYA's BRS contractors are not required to review or pursue third party resources. The Department and OYA must make reasonable efforts to obtain payment first from other resources consistent with OAR 410-120-1280(16) for Medicaid-eligible BRS clients.

(8) Public child-caring agencies who are responsible by rule or contract for the local match share portion of eligible Medicaid claims must comply with OAR 410-120-0035 and 42 CFR 433 Subpart B.

(9) In cases where the BRS contractor is not also the BRS provider, the BRS contractor is responsible for compensating the BRS provider for billable care days pursuant to the agency-approved subcontract between the BRS contractor and the BRS provider.

(10) The Authority may not be financially responsible for the payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid or CHIP program. If the Authority has previously paid the agency or BRS contractor for any claim that CMS disallows, the payment shall be recouped pursuant to OAR 410-120-1397. The Authority shall recoup or recover any other overpayments as described in OAR 410-120-1397 and 943-120-0350 and 943-120-0360.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 63-2013, f. 11-14-13, cert. ef. 1-1-14; DMAP 42-2015(Temp), f. & cert. ef. 8-11-15 thru 2-6-16; DMAP 4-2016(Temp), f. 2-5-16, cert. ef. 2-7-16 thru 8-4-16; DMAP 8-2016, f. & cert. ef. 2-23-16; DMAP 25-2016(Temp), f. & cert. ef. 6-3-16 thru 11-29-16; DMAP 64-2016, f. 11-23-16, cert. ef. 11-29-16

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Rule Caption: Transferring Rules from OHA Health Policy & Analytics to Health Systems Division, Medical Assistance Programs
Adm. Order No.: DMAP 65-2016
Filed with Sec. of State: 11-29-2016
Certified to be Effective: 11-29-16
Notice Publication Date: 11-1-2016

Rules Renumbered: 409-110-0025 to 410-110-0025, 409-110-0030 to 410-110-0030, 409-110-0035 to 410-110-0035, 409-110-0040 to 410-110-0040, 409-110-0045 to 410-110-0045
Subject: These rules establish criteria for awarding grants under the Safety Net Capacity Grant Program, which was established to ensure that safety net providers have capacity to serve vulnerable and underserved children in Oregon.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-110-0025
Scope

These rules establish criteria for awarding grants under the Safety Net Capacity Grant Program, which was established to ensure that safety net providers have capacity to serve vulnerable and underserved children in Oregon.

Stat. Auth: ORS 413.225
Stats. Implemented: ORS 413.225, 2015 c. 837 § 34 & 414.231
Hist.: OHP 8-2016(Temp), f. & cert. ef. 5-9-16 thru 11-4-16; OHP 15-2016, f. & cert. ef. 11-1-16; Renumbered from 409-110-0025, DMAP 65-2016, f. & cert. ef. 11-29-16

410-110-0030
Definitions

The following definitions apply to OAR 409-110-0025 to 409-110-0045:

(1) "Authority" means the Oregon Health Authority.

(2) "Community-sponsored Clinic" means a non-profit, community-based clinic that does not receive state or federal funding and is sponsored by the local community in the form of grants and donations, including in-kind donations of goods and services.

(3) "Culturally and Linguistically Appropriate Services" means health care services that are respectful of and responsive to cultural and linguistic needs. Please refer to the "National Standards on Culturally and Linguistically Appropriate Services" (CLAS), United States Department of Health and Human Services, Office of Minority Health.

(4) "Primary Healthcare Service" means physical, oral, mental, behavioral, and vision health services that are delivered in a manner that reflects the state's emphasis on patient-centered care.

(5) "Program" means the Safety Net Capacity Grant Program.

(6) "Safety Net Provider" means a public or non-profit federally qualified health center, school-based health center, tribal health clinic, rural health clinic, or community-sponsored clinic that provides primary care and preventive physical, oral, mental, behavioral and vision health services to low-income patients without charge or using a sliding scale.

(8) "Target Population" refers to children who are not eligible for the Oregon Healthy Kids Program for reasons other than income.

[ED.NOTE: Publications referenced are available from the agency]
Stat. Auth: ORS 413.225
Stats. Implemented: ORS 413.225, 2015 c. 837 § 34 & 414.231
Hist.: OHP 8-2016(Temp), f. & cert. ef. 5-9-16 thru 11-4-16; OHP 15-2016, f. & cert. ef. 11-1-16; Renumbered from 409-110-0030, DMAP 65-2016, f. & cert. ef. 11-29-16

410-110-0035
Program Administration

(1) The Program is intended to ensure that the target population has access to primary physical, oral, mental, behavioral, and vision health services.

(2) The Authority shall award grants to safety net providers through the Program.

(3) Services covered through the Program are limited to primary and preventive physical, oral, mental, behavioral, and vision health services.

(4) Children in the target population through the age of 18 are eligible to receive services through the program.

(5) The grant amount awarded shall take into consideration the distribution and concentration of the target population in the proposed service area.

(6) The Program is competitive and proposals that include collaboration with community partners may be given preference.

(7) The Authority shall administer the Program including soliciting, reviewing, evaluating, and selecting successful grant proposals. The Authority shall also provide project monitoring, technical assistance and submit periodic status reports to interested parties.

(8) Grant funding shall be awarded for the remainder of the 2015-2017 biennium, with the possibility of extensions.

(10) The Authority shall distribute safety net grant funds to successful applicants on an incremental basis.

Stat. Auth.: ORS 413.225
Stats. Implemented: ORS 413.225, 2015 c. 837 § 34
Hist.: OHP 8-2016(Temp), f. & cert. ef. 5-9-16 thru 11-4-16; OHP 15-2016, f. & cert. ef. 11-1-16; Renumbered from 409-110-0035, DMAP 65-2016, f. & cert. ef. 11-29-16

410-110-0040
Grant Award Process

(1) The Authority shall advertise grant proposals through publication on its website and through communication to eligible entities.

(2) All proposals must be submitted in a form specified by the Program and by the date specified in the solicitation document.

(3) The Authority shall document receipt of all proposals.

(4) To qualify for a grant through the Program, applicants must be able to credibly estimate the number of new and existing children in the target population they will serve, as well as the number of estimated visits for the target population.

(5) The Authority shall evaluate all proposals based upon but not limited to the following evaluation elements:

(a) Demonstrated capacity to provide primary health care services.

(b) Demonstrated capacity or description of a credible plan to serve the target population.

(c) Demonstrated capacity or description of a credible plan to assure that services are culturally and linguistically competent.

(d) Demonstrated capacity or description of a credible plan to identify, contact, and provide primary care services to the target population.

(e) Demonstrated readiness to be operational within 60 days of grant award.

(f) Maintenance of operating hours and locations to ensure accessibility.

(g) Demonstrated ability to partner with community-based and other community organizations and to leverage funds, where possible.

(h) Submission of a proposed work plan, including timeline, discrete programs and products, evaluation outcomes, and budget.

(i) Demonstrated capacity or description of a credible plan for implementing data systems that can report on delivery of services and health outcomes, preferably through the utilization of electronic health records that are Certification Commission for Health Information Technology certified.

(6) The Authority shall form a committee to consider and make recommendations on the submitted proposals.

(7) The Authority shall notify applicants, in writing, whether their proposal was selected for funding. The Authority shall provide a question and answer opportunity through electronic or telephone communication both before and after the selection of proposals.

Stat. Auth.: ORS 413.225
Stats. Implemented: ORS 413.225, 2015 c. 837 § 34 & 414.231
Hist.: OHP 8-2016(Temp), f. & cert. ef. 5-9-16 thru 11-4-16; OHP 15-2016, f. & cert. ef. 11-1-16; Renumbered from 409-110-0040, DMAP 65-2016, f. & cert. ef. 11-29-16

410-110-0045
Monitoring and Reporting Requirements

(1) A grantee shall:

(a) Submit grant reports to the Authority on a periodic basis. Grant reports will indicate progress to achieve grant benchmarks and goals and report on the expenditure of grant dollars. Failure to comply with reporting requirements may result in grant suspension or termination; and

(b) Report specific data or information, to be determined by the Authority.

(2) Grant disbursements are contingent on grantee achieving proposed service delivery levels. Failure to achieve proposed service levels or benchmarks may result in grant reduction or termination.

(3) Periodically grantee and the Authority shall jointly review progress.

Stat. Auth.: ORS 413.225
Stats. Implemented: ORS 413.225, 2015 c. 837 § 34 & 414.231
Hist.: OHP 8-2016(Temp), f. & cert. ef. 5-9-16 thru 11-4-16; OHP 15-2016, f. & cert. ef. 11-1-16; Renumbered from 409-110-0045, DMAP 65-2016, f. & cert. ef. 11-29-16

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Rule Caption: Prioritized List Effective October 1, 2016
Adm. Order No.: DMAP 66-2016
Filed with Sec. of State: 11-30-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 11-1-2016
Rules Amended: 410-141-0520
Rules Repealed: 410-141-0520(T)
Subject: The OHP program administrative rules govern the Division's payments for services provided to clients. The Authority needs to amend 410-141-0520. This change references the new interim modifications to the Centers for Medicare and Medicaid Services'

(CMS) approved biennial January 1, 2016-December 31, 2017, Prioritized List funded through line 475. These modifications include revised condition treatment pairings approved at the January 14, 2016, through August 11, 2016, HERC meetings not involving the changes to the prioritization of treatments for conditions of the back and spine already reflected in the July 1, 2016, Prioritized List. The October 1, 2016, Prioritized List includes revised line items and new/revised guideline notes and multisector interventions that supersede those found in the July 1, 2016, Prioritized List.
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, effective October 1, 2016, incorporates by reference new interim modifications to the Centers for Medicare and Medicaid Services' (CMS) approved biennial January 1, 2016–December 31, 2017, Prioritized List funded through line 475. These modifications include revised condition treatment pairings approved at the January 14, 2016, through August 11, 2016, HERC meetings not involving the changes to the prioritization of treatments for conditions of the back and spine already reflected in the July 1, 2016, Prioritized List. The October 1, 2016, Prioritized List includes revised line items and new/revised guideline notes and multisector interventions that supersede those found in the July 1, 2016, Prioritized List.

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; DMAP 55-2016(Temp), f. 9-22-16, cert. ef. 10-1-16 thru 12-27-16; DMAP 66-2016, f. 11-30-16, cert. ef. 12-1-16

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Rule Caption: Deletes Redundant Liability Limits for Coordinated Care Organizations
Adm. Order No.: DMAP 67-2016
Filed with Sec. of State: 11-30-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 11-1-2016
Rules Amended: 410-141-3435
Subject: This rule change deletes the reference in CCO rules to having transportation brokerages and their subcontrators having any specific level of liability insurance. There are already provisions in CCO rules regarding liability insurance responsibilities of CCOs and their subcontractors. The rule specific to transportation brokerages was both redundant in part and contradictory in part. Deleting this section of the rule will create a less confusing and more enforceable liability rule overall.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-3435
NEMT General Requirements

(1) A Coordinated Care Organization shall provide all NEMT services for its members. The Authority shall provide NEMT services in CCO's service area only to members not enrolled in a CCO.

(2) A CCO shall provide a toll-free call center for members to request rides.

(3) A CCO and its contracted transportation provider may not bill a member for any transport to and from medical services that are covered and where the CCO or its contracted transportation provider denied reimbursement.

(4) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3180 (Record Keeping and Use of Health Information Technology).

Stat. Auth.: ORS 413.042 & 414.625
Stats. Implemented: ORS 414.625
Hist.: DMAP 40-2014, f. & cert. ef. 7-1-14; DMAP 67-2016, f. 11-30-16, cert. ef. 12-1-16

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Rule Caption: Amending Prior Authorization Approval Criteria Guide
Adm. Order No.: DMAP 68-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 11-1-2016
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 October 13, 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; DMAP 54-2016(Temp), f. & cert. ef. 8-26-16 thru 12-27-16; DMAP 62-2016(Temp), f. & cert. ef. 10-13-16 thru 12-27-16; DMAP 68-2016, f. & cert. ef. 12-1-16

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Rule Caption: Amending PDL March 31, May 26, 2016 DUR/P&T Action
Adm. Order No.: DMAP 69-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 11-1-2016
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:
Epoprostenol
Narcan® Nasal
Injectable Naloxone
Lurasidone
Asenapine
Aripiprazole IM
Non-Preferred:
Calcium
Vitamin D
Evzio®
Auto Injector Naloxone
Glycopyrrolate
Indacaterol/Glycopyrrolate
Chlorpromazine

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 avail-

able 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 October 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; DMAP 57-2016(Temp), f. 9-30-16, cert. ef. 10-1-16 thru 3-29-17; DMAP 69-2016, f. & cert. ef. 12-1-16

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Rule Caption: Clearly Define Habilitative and Rehabilitative Therapies and Remove Client Copayments to Comply with Federal Requirements

Adm. Order No.: DMAP 70-2016(Temp)

Filed with Sec. of State: 12-5-2016

Certified to be Effective: 1-1-17 thru 6-29-17

Notice Publication Date:

Rules Amended: 410-129-0020, 410-129-0040, 410-129-0070, 410-131-0040, 410-131-0080, 410-131-0100, 410-131-0120

Rules Suspended: 410-129-0190

Subject: The state must not impose limits on habilitative services and devices that are more stringent than limits on rehabilitative services and devices. Amending rules to add clarity to defining habilitative and rehabilitative therapies and to remove client copayments to comply with federal requirements.

Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-129-0020

Therapy Plan of Care, Goals/Outcomes and Record Requirements

(1) Therapy shall be based on a prescribing practitioner's written order and therapy treatment plan with goals and objectives developed from an evaluation or re-evaluation. The limits, authorization, and plan of treatment criteria apply to both rehabilitative and habilitative therapy. The definition for both is the following:

(a) "Rehabilitative Services" means health care services that help keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to being sick, hurt, or disabled;

(b) "Habilitative Services" means health care services that help keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

(2) The therapy regimen shall be taught to individuals, including the patient, family members, foster parents, and caregivers who can assist in the achievement of the goals and objectives. The Division shall not authorize extra treatments for teaching.

(3) All speech-language pathology (SLP) treatment services require a therapy plan of care that is required for prior authorization (PA) for payment.

(4) The Division shall authorize for the level of care or type of service that meets the client's medical need consistent with the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) and guideline notes, dated October 1, 2016.

(5) The SLP therapy plan of care shall include:

(a) Client's name and diagnosis;

(b) The type, amount, frequency, and duration of the proposed therapy;

(c) Individualized, measurably objective, short-term and long-term functional goals;

(d) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and

(e) Evidence of certification of the therapy plan of care by the prescribing practitioner.

(6) SLP therapy records shall include:

(a) Documentation of each session;

(b) Therapy provided;

(c) Duration of therapy; and

(d) Signature of the speech-language pathologist.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065 & 681.205

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; DMAP 22-2014, f. & cert. ef. 4-2-14; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16; DMAP 70-2016(Temp), f. 12-5-16, cert. ef. 1-1-17 thru 6-29-17

410-129-0040

Maintenance

(1) Determination of when maintenance therapy is reached is made through comparison of written documentation of evaluation of the last several functional evaluations related to initial baseline measurements.

(2) Therapy becomes maintenance when any one of the following occur:

(a) The therapy treatment plan goals and objectives are reached and no further goals are needed; or

(b) There is no progress toward the rehabilitative or habilitative treatment plan goals and objectives; or

(c) The therapy treatment plan does not require the skills of a therapist; or

(d) The client, family, foster parents, or caregiver have been taught the therapy regimen and can carry out the maintenance therapy.

(3) Therapy that becomes maintenance is not a covered service.

(4) Re-evaluation to change the therapy plan of care and up to two treatments for brief retraining of the client, family, foster parents, or caregiver are not considered maintenance therapy and are reimbursable.

(5) Providers shall maintain adequate documentation as outlined in OAR 410-120-1360 Requirements for Financial, Clinical and Other Records.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065, 681.205 & 688.135
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16; DMAP 70-2016(Temp), f. 12-5-16, cert. ef. 1-1-17 thru 6-29-17

410-129-0070
Limitations

(1) SLP services:

(a) Shall be provided by a practitioner as described in OAR 410-129-0065(1);

(b) Rehabilitative and habilitative therapy treatment:

(A) May not exceed one hour per day each, either group or individual;

(B) Shall be either group or individual and may not be combined in the authorization period; and

(C) Requires PA.

(c) The following SLP services do not require payment authorization but are limited to:

(A) Two SLP evaluations in a 12-month period;

(B) Two evaluations for dysphagia in a 12-month period;

(C) Up to four re-evaluations in a 12-month period;

(D) One evaluation for speech-generating/augmentative communication system or device and shall be reimbursed per recipient in a 12-month period;

(E) One evaluation for voice prosthesis or artificial larynx and shall be reimbursed in a 12-month period;

(F) Purchase, repair, or modification of electrolarynx;

(G) Supplies for speech therapy and shall be reimbursed up to two times in a 12-month period, not to exceed $5 each;

(d) The purchase, rental, repair, or modification of a speech-generating/augmentative communication system or device requires PA. Rental of a speech-generating/ augmentative communication system or device is limited to one month. All rental fees shall be applied to the purchase price.

(2) Audiology and hearing aid services:

(a) All hearing services shall be performed by a licensed physician, audiologist, or hearing aid specialist;

(b) Reimbursement is limited to one (monaural) hearing aid every five years for adults (age 21 and older) who meet the following criteria: Loss of 45 decibel (dB) hearing level or greater in two or more of the following three frequencies: 1000, 2000, and 3000 Hertz (Hz) in the better ear;

(c) Adults who meet the criteria above and, in addition, have vision correctable to no better than 20/200 in the better eye may be authorized for two hearing aids for safety purposes. A vision evaluation shall be submitted with the PA request;

(d) Two (binaural) hearing aids shall be reimbursed no more frequently than every three years for children (birth through age 20) who meet the following criteria:

(A) Pure tone average of 25dB for the frequencies of 500Hz, 1000Hz and 2000Hz; or

(B) High frequency average of 35dB for the frequencies of 3000Hz, 4000Hz and 6000Hz.

(e) An assistive listening device may be authorized for individuals aged 21 or over who are unable to wear or who cannot benefit from a hearing aid. An assistive listening device is defined as a simple amplification device designed to help the individual hear in a particular listening situation. It is restricted to a hand-held amplifier and headphones;

(f) Services that do not require payment authorization:

(A) One basic audiologic assessment in a 12-month period;

(B) One basic comprehensive audiometry (audiologic evaluation) in a 12-month period;

(C) One hearing aid examination and selection in a 12-month period;

(D) One pure tone audiometry (threshold) test; air and bone in a 12-month period;

(E) One electroacoustic evaluation for hearing aid; monaural in a 12-month period;

(F) One electroacoustic evaluation for hearing aid; binaural in a 12-month period;

(G) Hearing aid batteries — maximum of 60 individual batteries in a 12-month period. Clients shall meet the criteria for a hearing aid.

(g) Services that require payment authorization:

(A) Hearing aids;

(B) Repair of hearing aids, including ear mold replacement;

(C) Hearing aid dispensing and fitting fees;

(D) Assistive listening devices;

(E) Cochlear implant batteries.

(h) Services not covered:

(A) FM systems — vibro-tactile aids;

(B) Earplugs;

(C) Adjustment of hearing aids is included in the fitting and dispensing fee and is not reimbursable separately;

(D) Aural rehabilitation therapy is included in the fitting and dispensing fee and is not reimbursable separately;

(E) Tinnitus maskers.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065 & 681.325
Hist.: HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 17-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 22-2014, f. & cert. ef. 4-2-14; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16; DMAP 70-2016(Temp), f. 12-5-16, cert. ef. 1-1-17 thru 6-29-17

410-129-0190
Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist. OMAP 80-2002, f. 12-24-02, cert. ef. 1-1-03; Suspended by DMAP 70-2016(Temp), f. 12-5-16, cert. ef. 1-1-17 thru 6-29-17

410-131-0040
Foreword for Physical and Occupation Therapy

(1) The Division Physical and Occupational Therapy (PT/OT) Services program rules are designed to assist licensed physical and occupational therapists deliver health care services and prepare health claims for clients with medical assistance program coverage. The limits, authorization, and plan of treatment criteria apply to both rehabilitative and habilitative therapy. The definition for both is the following:

(a) "Rehabilitative Services" means health care services that help keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to being sick, hurt, or disabled;

(b) "Habilitative Services" means health care services that help keep, learn, or improve skills and functioning for daily living. An example includes therapy for a child who isn't walking or talking at the expected age.

(2) Oregon Administrative Rules (OAR) 410-131-0040 through 410-131-0160:

(a) Apply to services delivered by home health agencies and by hospital-based therapists in the outpatient setting. Billing and reimbursement for therapy services delivered by home health agencies and hospital outpatient departments are to be in accordance with the rules in their respective provider guides; and

(b) Do not apply to services provided to hospital inpatients.

(3) The Division enrolls only the following types of providers as performing providers under the PT/OT program:

(a) An individual licensed by the relevant state licensing authority to practice physical therapy; and

(b) An individual licensed by the relevant state licensing authority to practice occupational therapy.

(4) The PT/OT program rules contain information on policy, prior authorization, and service coverage and limitations for some procedures. All Division rules are intended to be used in addition to the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 division 141).

(5) The Oregon Health Evidence Review Commission Prioritized List of Health Services is found in OAR 410-141-0520 and defines the services covered under the Division.

(6) The PT/OT provider shall understand and follow all Division rules that are in effect on the date services are provided.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.065

Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; DMAP 35-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16; DMAP 70-2016(Temp), f. 12-5-16, cert. ef. 1-1-17 thru 6-29-17

410-131-0080
Therapy Plan of Care and Record Requirements

(1) A therapy plan of care is required for PA for payment.

(2) The Division shall authorize for the level of care or type of service that meets the client's medical need consistent with the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) and guideline notes, dated October 1, 2016.

(3) The therapy plan of care shall include:

(a) Client's name, diagnosis, and type, amount, frequency, and duration of the proposed therapy;

(b) Individualized, measurably objective functional goals;

(c) Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;

(d) Plan to address implementation of a home management program as appropriate from the initiation of therapy forward;

(e) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and

(f) For home health clients, any additional requirements included in OAR chapter 410 division 127.

(4) The therapy treatment plan and regimen shall be taught to the client, family, foster parents, or caregiver during the therapy treatments. No extra treatments shall be authorized for teaching.

(5) A therapy plan of care shall comply with the relevant state licensing authority's standards.

(6) If a state licensing authority has not adopted therapy plan of care standards, the therapy plan of care shall include:

(a) The need for continuing therapy clearly stated;

(b) Changes to the therapy plan of care, including changes to duration and frequency of intervention; and

(c) Any changes or modifications to the plan of care shall be documented, signed, and dated by the prescribing practitioner or therapist who developed the plan.

(7) Therapy records shall include:

(a) A written referral, including:

(A) The client's name;

(B) The ICD-10-CM diagnosis code; and

(C) Specification of the type of services, amount, and duration required.

(b) A copy of the signed therapy plan of care shall be on file in the provider's therapy record prior to billing for services;

(c) Documents, evaluations, re-evaluations, and progress notes to support the therapy treatment plan and prescribing provider's written orders for changes in the therapy treatment plan;

(d) Modalities used on each date of service;

(e) Procedures performed and amount of time spent performing the procedures is documented and signed by the therapist; and

(f) Documentation of splint fabrication and time spent fabricating the splint.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 688.135, 414.065
Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 35-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 65-2014, f. 10-30-14, cert. ef. 11-4-14; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16; DMAP 70-2016(Temp), f. 12-5-16, cert. ef. 1-1-17 thru 6-29-17

410-131-0100
Maintenance

(1) Determination of when maintenance therapy is reached is made through comparison of written documentation of evaluation of the last several functional evaluations related to initial baseline measurements.

(2) Therapy becomes maintenance when any one of the following occur:

(a) The therapy treatment plan goals and objectives are reached and no further goals are needed; or

(b) There is no progress toward the rehabilitative or habilitative treatment plan goals and objectives; or

(c) The therapy treatment plan does not require the skills of a therapist; or

(d) The client, family, foster parents, or caregiver have been taught the therapy regimen and can carry out the maintenance therapy.

(3) Maintenance therapy is not a reimbursable service.

(4) Re-evaluation to change the therapy plan of care and up to two treatments for brief retraining of the client, family, foster parents, or caregiver are not considered maintenance therapy and are reimbursable.

(5) Providers shall maintain adequate documentation as outlined in OAR 410-120-1360 Requirements for Financial, Clinical and Other Records.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 35-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2016, f. 7-26-16, cert. ef. 8-1-16; DMAP 70-2016(Temp), f. 12-5-16, cert. ef. 1-1-17 thru 6-29-17

410-131-0120
Limitations of Coverage and Payment

(1) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services shall be supported by a therapy plan of care signed and dated by the prescribing practitioner.

(2) PT/OT initial evaluations and re-evaluations do not require PA, but are limited to:

(a) Up to two initial evaluations in any 12-month period; and

(b) Up to four re-evaluation services in any 12-month period.

(3) Reimbursement is limited to the initial evaluation when both the initial evaluation and a re-evaluation are provided on the same day.

(4) All other occupational and physical therapy treatments require PA. See also OAR 410-131-0160 and Table 131-0160-1.

(5) A licensed occupational or physical therapist or a licensed occupational or physical therapy assistant under the supervision of a therapist shall be in constant attendance while therapy treatments are performed:

(a) Rehabilitative and habilitative therapy treatments may not exceed one hour per day each for occupational and physical therapy;

(b) Modalities:

(A) Require PA;

(B) Up to two modalities may be authorized per day of treatment;

(C) Need to be billed in conjunction with a therapeutic procedure code; and

(D) Each individual supervised modality code may be reported only once for each client encounter. See Table 131-0160-1.

(c) Massage therapy is limited to two units per day of treatment and shall only be authorized in conjunction with another therapeutic procedure or modality.

(6) Supplies and materials for the fabrication of splints shall be billed at the acquisition cost, and reimbursement may not exceed the Division's maximum allowable in accordance with the physician fee schedule. Acquisition cost is purchase price plus shipping. Off-the-shelf splints, even when modified, are not included in this service.

(7) The following services are not covered:

(a) Services not medically appropriate;

(b) Services that are not paired with a funded diagnosis on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services pursuant to OAR 410-141-0520;

(c) Work hardening;

(d) Back school and back education classes;

(e) Hippotherapy (e.g., horse or equine-assisted therapy);

(f) Services included in OAR 410-120-1200 Excluded Services Limitations;

(g) Durable medical equipment and medical supplies other than those splint supplies listed in Table 131-0120-1 and OAR 410-131-0280.

(8) Physical capacity examinations are not a part of the PT/OT program but may be reimbursed as administrative examinations when ordered by the local branch office. See OAR chapter 410, division 150, for information on administrative examinations and report billing.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 688.135, 414.065
Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92; HR 28-1993, f. & cert. ef. 10-1-93; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95; HR 2-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 8-1998, f. & cert. ef. 3-2-98; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 64-2003, f. 9-8-03, cert. ef. 10-1-03; OMAP 59-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 15-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 35-2011, 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 49-2016, f. 7-26-16, cert. ef. 8-1-16; DMAP 70-2016(Temp), f. 12-5-16, cert. ef. 1-1-17 thru 6-29-17

Oregon Health Authority,
Health Systems Division: Mental Health Services
Chapter 309

Rule Caption: Permanent new rules 309-008 regarding certifications of behavioral health treatment services.
Adm. Order No.: MHS 16-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 11-30-16
Notice Publication Date: 9-1-2016
Rules Adopted: 309-008-0100, 309-008-0200, 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, 309-008-0250
Subject: 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.

These procedural rules apply to providers of behavioral health treatment services seeking certification to provide services issued under the following other rules:

OAR 309-014, 309-014, 309-018, 309-019, 309-022, 309-033-0700 - 0580, 309-039, 415-020, 415-054, 415-055 and 415-057.
Rules Coordinator: Nola Russell—(503) 945-7652

309-008-0100
Purpose and Scope

(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 the following of certificates 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 309-019-0100 to 0220 (Outpatient Addictions and Mental Health Services);

(c) OAR 309-022-0100 to 0190 (Intensive Treatment Services for Children and Adolescents);

(d) OAR 309-022-0195 to 0230 Children's Emergency Safety Intervention Specialist);

(e) OAR 309-033-0700 to 0740 (Community Hospital and Nonhospital Facilities to provide Seclusion and Restraint to Committed Persons and Persons in Custody or in Diversion);

(f) OAR 309-039-0500 to 0580 (Non-Inpatient Mental Health Treatment Services);

(g) OAR 415-020-0000 to 0090 (Out-Patient Opioid Treatment Programs);

(h) OAR 415-054-0020 to 0580 (DUII Alcohol/Other Drug Information and DUII Alcohol/Other Drug Rehabilitation Programs);

(i) OAR 415-054-0400 to 0580 (Alcohol and Drug Evaluation and Screening Specialist);

(j) 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

(k) 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.

(4) These rules apply to applications, initial certifications, renewals of certification, reviews, and other actions that were pending or initiated on or after July 1, 2016.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 413.042, 413.032-413.033, 426.072, 426.236, 426.500, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168
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; MHS 12-2016(Temp), f. & cert. ef. 7-29-16 thru 12-27-16; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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.

(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, 426.140, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 743.556, 813.021, & 813.260

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 12-2016(Temp), f. & cert. ef. 7-29-16 thru 12-27-16; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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 compliance 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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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.

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Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 16-2016, f. 11-28-16, cert. ef. 11-30-16

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Rule Caption: Permanent amendments to 309-018 titled "Residential Substance Use and Problem Gambling Treatment and Recovery Services".
Adm. Order No.: MHS 17-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 11-28-16
Notice Publication Date: 10-1-2016
Rules Adopted: 309-018-0107
Rules Amended: 309-018-0100, 309-018-0105, 309-018-0160, 309-018-0215, 309-018-0210
Subject: These rules prescribe standards by which the Health Systems Division of the Oregon Health Authority (OHA) licenses community based residential treatment facilities (RTF) and community based residential treatment homes (RTH) for adults with mental or emotional disorders. The standards promote optimum health, mental and social well-being, and recovery of adults with mental or emotional disorders through the availability of a wide range of home and community based residential settings and services. They prescribe how services will be provided in safe, secure and homelike environments that recognize the dignity, individuality and right to self-determination of each individual.

(a) These rules incorporate and implement the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services for home and community based services (HCBS) authorized under section 1915(i) of the Social Security Act.

(b) These rules establish requirements to ensure individuals receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving HCBS consistent with the standards set out in OAR Chapter 411, Division 4.
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, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 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; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16

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, adoption, 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, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 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; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16

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, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 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; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16

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, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 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; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16

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 or 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, 430.254 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.055 & 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; MHS 17-2016, f. 11-28-16, cert. ef. 11-30-16

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Rule Caption: Permanent amendments to OAR 309-019 titled "Outpatient Addictions and Mental Health Services".
Adm. Order No.: MHS 18-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 11-30-16
Notice Publication Date: 10-1-2016
Rules Adopted: 309-019-0225, 309-019-0230, 309-019-0235, 309-019-0240, 309-019-0245, 309-019-0250, 309-019-0255, 309-019-0248
Rules Amended: 309-019-0100, 309-019-0105, 309-019-0135, 309-019-0175, 309-019-0110, 309-019-0125, 309-019-0130, 309-019-0140, 309-019-0145, 309-019-0195, 309-019-0210, 309-019-0220, 309-019-0215
Subject: Permanent new rules, and amendments to other rules, all which implement integrated changes to the Health Systems Division's (HSD) provider certification processes. The changes reflect that HSD will provide the certification of Community Mental Health Programs' (CMHP) subcontracted providers, a duty the CMHPs previously provided. The changes will also decrease the administrative burdens for HSD, and for the providers of related services.
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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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 fam-

ily 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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

309-019-0135

Entry and Assessment

(1) Entry Process: The program must utilize an 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 develop and maintain adequate clinical records and other documentation which supports the specific care, items, or services for which payment has been requested.

(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.

(g) 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) An opportunity to complete a declaration for mental health treatment with the individual's participation and informed consent;

(B) A description of individual rights consistent with these rules;

(C) Policies concerning grievances;

(D) Notice of privacy practices; and

(E) An opportunity to register to vote.

(2) Entry Priority: Entry of individuals whose services are funded by the SAPT Block Grant, must be prioritized in the following order:

(A) Women who are pregnant and using substances intravenously;

(B) Women who are pregnant;

(C) Individuals who are using substances intravenously; and

(D) Women with dependent children.

(3) Assessment:

(a) At the time of entry, an assessment must be completed.

(b) The assessment must be completed by qualified program staff as follows:

(A) A QMHP in mental health programs. A QMHA may assist in the gathering and compiling of information to be included in the assessment.

(B) Supervisory or treatment staff in substance use disorders treatment programs, and

(C) Supervisory or treatment staff in problem gambling treatment programs.

(c) Each assessment must include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services.

(d) For Substance Use Disorders services, each assessment must be consistent with the dimensions described in the ASAM PPC, and must document a diagnosis and level of care determination consistent with the DSM and ASAM PPC.

(e) When the assessment process determines the presence of co-occurring substance use and mental health disorders, or any significant risk to health and safety, all 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) Providers must periodically update assessments as applicable, when there are changes in clinical circumstances; and

(f) Any individual continuing to receive mental health services for one or more continuous years, must receive an annual assessment by a QMHP.

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 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

309-019-0175

Outpatient Substance Use Disorders Treatment and Recovery Services

(1) Interim Referral and Information Services: Pregnant women or other individuals using substances intravenously, whose services are funded by the SAPT Block Grant, must receive interim referrals and information prior to entry, to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services must include:

(a) Counseling and education about blood borne pathogens including Hepatitis, HIV, STDs and Tuberculosis (TB); the risks of needle and paraphernalia sharing and the likelihood of transmission to sexual partners and infants;

(b) Counseling and education about steps that can decrease the likelihood of Hepatitis, HIV, STD, and TB transmission;

(c) Referral for Hepatitis, HIV, STD and TB testing, vaccine or care services if necessary; and

(d) For pregnant women, counseling on the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco and other drug use on the fetus and referral for prenatal care.

(2) Culturally Specific Services: Programs approved and designated as culturally specific programs must meet the following criteria:

(a) Serve a majority of individuals representing culturally specific populations;

(b) Maintain a current demographic and cultural profile of the community;

(c) Ensure that individuals from the identified cultural group receive effective and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language;

(d) Implement strategies to recruit, retain, and promote a diverse staff at all levels of the organization that are representative of the population being served;

(e) Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery;

(f) Providers should ensure that a majority of the substance use disorders treatment staff be representative of the specific culture being served;

(g) Ensure that individuals are offered customer satisfaction surveys that address all areas of service and that the results of the surveys are used for quality improvement;

(h) Consider race, ethnicity, and language data in measuring customer satisfaction;

(i) Develop and implement cultural competency policies;

(j) Ensure that data on individual's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated;

(k) Develop and maintain a Governing or Advisory Board as follows:

(A) Have a majority representation of the culturally specific group being served;

(B) Receive training concerning the significance of culturally relevant services and supports;

(C) Meet at least quarterly; and

(D) Monitor agency quality improvement mechanisms and evaluate the ongoing effectiveness and implementation of culturally relevant services (CLAS) and supports within the organization.

(l) Maintain accessibility to culturally specific populations including:

(A) The physical location of the program must be within close proximity to the culturally specific populations;

(B) Where available, public transportation must be within close proximity to the program; and

(C) Hours of service, telephone contact, and other accessibility issues must be appropriate for the population.

(m) The physical facility where the culturally specific services are delivered must be psychologically comfortable for the group including:

(A) Materials displayed must be culturally relevant; and

(B) Mass media programming (radio, television, etc.) must be sensitive to cultural background;

(n) Other cultural differences must be considered and accommodated when possible, such as the need or desire to bring family members to the facility, play areas for small children and related accommodations; and

(o) Ensure that grievance processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints.

Stat. Auth.: ORS 413.042, 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

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 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

309-019-0210
Quality Assessment and Performance Improvement

Providers must develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families.

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 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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).

(a) 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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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) & (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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

309-019-0250
Transition to Less Intensive Services

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:

(1) Have successfully reached individually established goals for transition.

(2) 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;

(3) When the individual requests discharge, declines, or refuses services; and

(4) 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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 18-2016, f. 11-28-16, cert. ef. 11-30-16

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Rule Caption: Permanent amendments to OAR 309-039 regarding approval of providers of non-inpatient mental health treatment services.
Adm. Order No.: MHS 19-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 11-30-16
Notice Publication Date: 10-1-2016
Rules Amended: 309-039-0500, 309-039-0530, 309-039-0580, 309-039-0510
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 no 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; MHS 19-2016, f. 11-28-16, cert. ef. 11-30-16

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 309-008-0100 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; MHS 19-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 19-2016, f. 11-28-16, cert. ef. 11-30-16

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; MHS 19-2016, f. 11-28-16, cert. ef. 11-30-16

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Rule Caption: Repeals of OAR 309-012-0130 thru 309-012-0230 regarding certificates for providing mental health services.
Adm. Order No.: MHS 20-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 10-1-2016
Rules Repealed: 309-012-0130, 309-012-0140, 309-012-0150, 309-012-0160, 309-012-0170, 309-012-0180, 309-012-0190, 309-012-0200, 309-012-0210, 309-012-0220, 309-012-0230
Subject: These rules establish procedures for approval of the following kinds of organizations:

1. Any mental health service provider whhich 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

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Rule Caption: Permanent amendments to OAR 309-022 regarding Intensive Treatment for Children and Cheldrens' Emergency Safety Intervention.

Adm. Order No.: MHS 21-2016

Filed with Sec. of State: 12-1-2016

Certified to be Effective: 12-1-16

Notice Publication Date: 10-1-2016

Rules Amended: 309-022-0100, 309-022-0105, 309-022-0135, 309-022-0175, 309-022-0205

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

309-022-0100

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 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.

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; MHS 21-2016, f. & cert. ef. 12-1-16

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. (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, adoption, 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; MHS 21-2016, f. & cert. ef. 12-1-16

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; MHS 21-2016, f. & cert. ef. 12-1-16

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; MHS 21-2016, f. & cert. ef. 12-1-16

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; MHS 21-2016, f. & cert. ef. 12-1-16

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Rule Caption: Permanent amendments to OAR 309-032 regarding acute care psychiatric services.
Adm. Order No.: MHS 22-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 10-1-2016
Rules Amended: 309-032-0850, 309-032-0860, 309-032-0870, 309-032-0890
Subject: These rules prescribe standards and procedures for acute care psychiatric services.
Rules Coordinator: Nola Russell—(503) 945-7652

309-032-0850
Purpose

Purpose: These rules prescribe standards and procedures for regional acute care psychiatric services for adults.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 430.630 & 430.640

Hist. MHD 8-1994, f. & cert. ef. 11-28-94; MHS 22-2016, f. & cert. ef. 12-1-16

309-032-0860
Definitions

As used in these rules:

(l) "Adult" means a person age 18 years or older.

(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.

(2) "Clinical record" means a separate file established and maintained under these rules for each patient.

(3) "Community mental health program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the Division.

(4) "Council" means an organization of persons, with a mission statement and by-laws, comprised of representatives of the regional acute care psychiatric service, state hospital, community mental health programs served, consumers, and family members. The Council is advisory to the regional acute care facility for adults.

(5) "Diagnosis" means a DSM diagnosis determined through the mental health assessment and any examinations, laboratory, medical or psychological tests, procedures, or consultations suggested by the assessment.

(6) "Division" means the Health Systems Division of the Oregon Health Authority.

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

(8) "Goal" means the broad aspirations or outcomes toward which the patient is striving, and toward which all services are intended to assist the patient.

(9) "Guardian" means a person appointed by a court of law to act as a guardian of a legally incapacitated person.

(10) "Independent medical practitioner" means a medically trained person who is licensed to practice independently in the State of Oregon and has one of the following degrees: MD (Medical Doctor), DO (Doctor of Osteopathy), or NP (Nurse Practitioner).

(11) "Legally incapacitated" means having been found by a court of law under ORS 126.103 or 426.295 to be unable, without assistance, to properly manage or take care of one's personal affairs.

(12) "Linkage agreement" means a written agreement between the regional acute care psychiatric services, the local community mental health programs, and state hospitals which describes the roles and responsibilities each assumes in order to assure that the goals of the regional acute care psychiatric services are achieved.

(13) "Medical director" means a board eligible psychiatrist who oversees the patient care program. The medical director shall have the final authority concerning inpatient medical care including admissions, continuing care, and discharges.

(14) "Medical history" means a review of the patient's current and past state of health as reported by the patient or other reliable sources, including, but not limited to:

(a) History of any significant illnesses, injuries, allergies, or drug sensitivities; and

(b) History of any significant medical treatments, including hospitalizations and major medical procedures.

(15) "Mental health assessment" means a process in which the person's need for mental health services is determined through evaluation of the patient's strengths, goals, needs, and current level of functioning.

(16) "Mental status examination" means an overall assessment of a person's mental functioning that includes descriptions of appearance, behavior, speech, mood and affect, suicidal/homicidal ideation, thought processes and content, and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, memory, concentration, general knowledge, abstraction abilities, judgment, and insight.

(17) "Objective" means an interim level of progress or a component step the specification of which is necessary or helpful in moving toward a goal.

(18) "Office" means the Office of Mental Health Services of the Division.

(19) "OPRCS" means the Oregon Patient/Resident Care System. OPRCS is a Division operated, on-line computerized information system which accepts, stores and returns information about patients from state operated institutions and other designated inpatient services.

(20) "Patient" means a person who is receiving care and treatment in a regional acute care psychiatric service.

(21) "Person committed to the Division" means a patient committed under ORS 161.327 or 426.130.

(22) "Program administrator" means a person, with appropriate professional qualifications and experience, appointed by the governing body to manage the operation of the regional acute care psychiatric services.

(23) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.492 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(24) "Qualified mental health professional" or "QMHP" means a person who is one of the following:

(a) Psychiatrist or physician, licensed to practice in the State of Oregon; an individual with a graduate degree in psychology, social work, or other mental health related field; a registered nurse with a graduate degree in psychiatric nursing, licensed in the State of Oregon; an individual with registration as an occupational therapist; an individual with a graduate degree in recreational therapy; or

(b) Any other person whose education, experience, and competence have been documented by the CMHP director or designee as able to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social, and work relationships, conduct a mental status assessment; document a DSM diagnosis; write and supervise a rehabilitation plan; and provide individual, family, and/or group therapy.

(25) "Regional acute care psychiatric service" or "service" means a Division funded service provided under contract with the Division or county, and operated in cooperation with a regional or local council. A regional acute care psychiatric service must include 24 hour-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults ages 18 and older with severe psychiatric disabilities in a designated region of the State. For the purpose of these rules, a state hospital is not a regional acute care psychiatric service. The goal of a regional acute care service is the stabilization, control and/or amelioration of acute dysfunctional symptoms or behaviors that result in the earliest possible return of the person to a less restrictive environment.

(26) "Supervisor" means a person who has two years of experience as a qualified mental health professional and who, in accordance with Section 309-032-0870 of these rules, reviews the services provided to patients by qualified persons.

(27) "Treatment plan" means an individualized, written plan defining specific rehabilitation objectives and proposed service interventions derived from the patient's mental health assessment.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.630 & 430.640
Hist. MHD 8-1994, f. & cert. ef. 11-28-94; MHS 22-2016, f. & cert. ef. 12-1-16

309-032-0870
Standards for Approval of Regional Acute Care Psychiatric Service

(1) State approvals and licenses. The facility in which a regional acute care psychiatric service is provided shall maintain state certificates and licenses as required by Oregon law for the health, safety, and welfare of the persons served. Non-hospital facilities shall be licensed by the Division as required by ORS 443.410. Non-hospital facilities will be certified by the Division as required by OAR 309-008-0100 to 309-008-1600. The facility must also be approved under OAR 309-033-0530 Approval of Hospitals and Nonhospital Facilities that Provide Services to Committed Persons and to Persons in Custody or on Diversion and OAR 309-033-0540, Administrative Requirements for Hospitals and Nonhospital Facilities Approved to Provide Services to Persons in Custody, Psychiatric Hold or Certified for 14 Days of Intensive Treatment.

(2) Clinical record management. A regional acute care psychiatric service shall maintain clinical records as follows:

(a) Clinical records are confidential, as set forth in ORS 179.505 and 192.502 and any other applicable state or federal law, except as otherwise indicated by applicable rule or law. For the purposes of disclosure from non-medical individual records, both the general prohibition against disclosure of "information of a personal nature" and limitations to the prohibition in ORS 192.502 shall be applicable.

(b) Clinical records shall be secured, safeguarded, stored, and retained in accordance with OAR 166-030-1015.

(c) Clinical record entries required by these rules must be signed by the staff providing the service and making the entry. Each signature must include the person's academic degree or professional status and the date signed.

(3) Clinical record content. The clinical record shall contain:

(a) Identifying demographic information, including, if available, who to contact in an emergency and the names of persons who encompass the support system of the patient.

(b) Consent to release information and explanation of fee policies. At the time of admission staff shall present the patient with forms for obtaining consent so that information may be shared with family and others. An explanation of fee policies shall also be provided in written form at the earliest time possible. The patient shall be asked to sign each. If the patient is unwilling or unable to sign, staff shall record that the person is unable or unwilling to do so.

(c) Admitting mental health assessment. An admitting mental health assessment shall be completed, by or under the supervision of an independent medical practitioner with supervised training or experience in a mental health related setting, within 24 hours of admission. The admitting mental health assessment shall include a description of the presenting problem(s), a mental status examination, an initial DSM diagnosis, and an assessment of the resources currently available to the person. The assessment shall result in a plan for the initial services to be provided. The admitting mental health assessment shall also include documentation that a medical history and physical examination of the person has been performed within 24 hours after admission by a physician, physician assistant, or nurse practitioner. If the independent medical practitioner believes a new medical history and physical examination are not necessary, and if within 30 days of admission a complete physical history has been recorded and a complete physical examination has been performed, the signed report of the history and examination may be placed in the clinical record and may be considered to constitute an appropriate physical health assessment.

(d) Psycho-social assessment. A psycho-social assessment shall be completed for each patient within 72 hours of admission. If the patient stays less than 72 hours, a psycho-social assessment need not be written. The assessment must be completed by a qualified mental health professional or supervisor. The assessment does not need to be a single document but must include the following elements:

(A) A description of events precipitating admission and any goal(s) of the patient in seeking or entering services.

(B) When relevant to the patient's service needs, historical information including: mental health history; medical history; substance use and abuse history; developmental history; social history, including family and interpersonal history; sexual and other abuse history; educational, vocational, employment history; and legal history.

(C) An identification of the patient's need for assistance in maintaining financial support, employment, housing, and other support needs.

(D) Recommendations for discharge planning and any additional services, interventions, additional examinations, tests, and evaluations that are needed.

(e) Treatment plan. A treatment plan, individually developed with the patient from the findings of the admitting mental health assessment and psycho-social assessment, must be completed by a QMHP or supervisor within 72 hours of the person's admission. The plan must be written at a level of specificity that will permit its subsequent implementation to be efficiently monitored and reviewed. The recorded plan shall contain the following components:

(A) The rehabilitation and other goals, including those articulated by the patient.

(B) Specific objectives, including discharge objectives, and the measurable or observable criteria for determining when each objective is attained;

(C) Specific services to be used to achieve each objective;

(D) The projected frequency and duration of services;

(E) Identification of the QMHP or supervisor assigned to the patient who is responsible for coordinating services;

(F) The signature of the patient indicating he/she has participated in the development of the plan to the degree possible. If the patient is unwilling or unable to sign the plan, staff shall record on the plan that the patient is unable or unwilling to do so.

(G) The plan must be reviewed weekly and updated with the participation of the patient when needed to reflect significant changes in the patient's status, and when significant new goals are identified.

(f) Progress notes. Progress notes shall document observations, treatment rendered. response to treatment, and changes in the patient's condition, and other significant information relating to the patient. All entries involving subjective interpretation of the patient's progress shall be supplemented by a description of the actual behavior observed.

(g) Reports of medication administration, medical treatments, and diagnostic procedures.

(h) Telephone communications about the patient, releases of information, and reports from other sources.

(i) The record shall contain medical and mental health advance directives or note that the patient has been provided this information.

(j) The record shall contain documentation that the person has been provided information on patient rights, grievance procedure, and abuse reporting.

(k) The record shall contain documentation including physician's orders and reasons for all restraint and seclusion episodes.

(l) Discharge plan. The discharge planning shall begin at the time of admission with the participation of the patient and, when indicated, the family, guardian and significant others. The discharge plan shall include the results of the admitting mental health assessment; DSM diagnoses; summary of the course of treatment, including prescribed medications; final assessment of the person's condition; recommendations and arrangements for further treatment including prescribed medications and continuing care; and documentation of the planning for, and securing of appropriate living arrangements.

(4) Patient data management. The regional acute care psychiatric service shall supply to the Division, using the Division's on-line Oregon Patient/Resident Client System (OPRCS), via computer and modem, information about persons admitted to and discharged from the service. Such information shall include the patient's name, DSM diagnosis, admission date, discharge date, legal status, Medicaid eligibility, Medicaid Prime Number and various patient demographics. Such information shall be entered on the day of admission and updated on the day of discharge.

(5) Professional staff standards. The regional acute care psychiatric service shall:

(a) Have sufficient appropriately qualified professional, administrative and support staff to assess and address the identified clinical needs of persons served, provide needed services, and coordinate the services provided.

(b) Designate a program administrator to oversee the administration of the services and carry out these rules.

(c) Designate a medical director to oversee the patient care program. The medical director shall have the final authority concerning inpatient medical care including admissions, continuing care, and discharges.

(d) Designate an individual responsible for maintaining, controlling and supervising medical records and be responsible for maintaining the quality of clinical records.

(e) Designate an individual responsible for the development, implementation and monitoring of a written safety management plan and program, who shall keep records of identified concerns and problems and actions taken to resolve them.

(f) Designate an individual responsible for the development, implementation and monitoring of a written infection control plan and program, who shall keep records of identified concerns and problems and action taken to resolve them.

(g) Designate, or contract with, a licensed pharmacist to be responsible for the development of pharmacy policies and procedures, and to assure that the service adheres to standards of practice and applicable state and federal laws and regulations.

(h) Maintain a schedule of unit staffing which shall be readily available to the Division for a period of at least the three previous years.

(i) Have on duty at least one registered nurse at all times.

(j) Maintain a personnel file for each patient care staff which includes a written job description; the minimum level of education or training required for the position; copies of applicable licenses, certifications, or degrees granted; annual performance appraisals; a biennial, individualized staff development plan signed by the staff; documentation of CPR training; documentation of annual training and certification in managing aggressive behavior, including seclusion and restraint; and other staff development and/or skill training received.

(k) A physician must be available, at least on-call, at all times.

(6) Policies and procedures manual. The regional acute care psychiatric service shall have a policy and procedure manual. The policy and procedure manual must be made available to any person upon request. The manual shall describe:

(a) The following policies and procedures:

(A) Governance and management, including: a table of organization describing the agency structure and lines of authority; a plan for professional services; and a plan for financial management and accountability.

(B) Procedures for the management of disasters, fire, and other emergencies.

(C) Policies and procedures required under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion addressing seclusion and restraint.

(D) Patient rights, including informed consent, access to records, and grievance procedure. The manual shall assure rights guaranteed by ORS 426.380 to 426.395 for committed persons and ORS 430.205 to 430.210 for those not committed. The grievance procedure must be in writing and include written responses, time limits for responses, use of a neutral party and a method of appeal. Programs shall post copies of the rights and grievance procedures in places accessible to all persons. Programs shall provide written copies of the rights and grievance procedure upon request.

(E) Abuse reporting for mentally ill or developmentally disabled as required by ORS 430.731 through 430.768.

(F) Clinical record content and management policies and procedures, including the requirements of these rules.

(G) Psychiatric, medical, and dental emergency services policies and procedures.

(H) Pharmacy services policies and procedures approved by a licensed pharmacist.

(I) Quality assessment and improvement processes.

(J) Procedures for documenting privileges granted by the service in personnel records or other records.

(K) Policies and procedures for transfer of patients to other hospitals.

(b) The following policies and procedures, developed and amended in consultation with the council:

(A) Patient admission and discharge criteria. Unless the service has a policy and procedure recommended by the council and approved by the Division, the service shall only admit persons age 18 and older.

(B) Quality assessment and improvement processes relating to regional admissions and discharges.

(C) Patient admission, discharge and aftercare planning; including scheduling and planning for transportation of patients to the service by the referring county and from the service to the county of residence.

(D) Procedures for admission and discharge of geropsychiatric patients and persons with physical disabilities, including designation of a county or regional geropsychiatric liaison staff member.

(E) Linkage agreements with community mental health programs it serves and state hospitals.

(F) Medical and emergency care procedures, approved by the Division.

(G) Criteria for accepting pre-admission medical screening.

(H) Billing and collecting reimbursement from patients and third-party payors.

(7) Holding allegedly mentally ill persons. The service shall have an adequate number of hold rooms but at least one holding room and hold a current Certificate of Approval to hold and treat persons who are alleged to be mentally ill under OAR 309-033-0500 through 309-033-0560, Approval of Hospital and Nonhospital Facilities that Provide Services to Committed Persons or to Persons in Custody or on Diversion.

(8) Federal rules and regulations. The facility in which a service is operated shall comply with all applicable federal rules and regulations.

(9) Medical care. If the facility in which the regional acute care psychiatric service is operated is not in a general hospital, it shall have a letter of agreement with a general hospital for both emergency and medical care, which shall be renewed every two years.

(10) Quality assessment and improvement. The regional acute care psychiatric service shall have an ongoing quality assessment and improvement program to objectively and systematically monitor and evaluate the quality of care provided to patients served, pursue opportunities to improve care and correct identified problems. The program shall include:

(a) Policies and procedures that describes the quality assessment and improvement program's objectives, organization, scope, and mechanisms for improving services.

(b) A written annual plan to monitor and evaluate services. The written plan shall result in reports of findings, conclusions, and recommendations. Reports shall address:

(A) The care of patients served, including admission and discharge planning;

(B) Resource utilization, including the appropriateness and clinical necessity of admissions and continued stay, services provided, staffing levels, space, and support services;

(C) Quality and content of clinical records;

(D) Medication usage, including records, adverse reactions, and medication errors;

(E) Accidents, injuries, safety of patients, and safety hazards; and

(F) Uses of seclusion and restraint.

(c) A report to the governing board and council, at least annually, addressing:

(A) Findings and conclusions from studies;

(B) Recommendations, action taken, and results of the action taken; and

(C) An assessment of the effectiveness of the quality assessment and improvement program; including a review of the program's objectives, scope, organization and effectiveness.

(11) Council. The regional acute care psychiatric service shall have a council to ensure appropriate and effective care and treatment. The council shall meet to assess and collaboratively plan for improving care and treatment to patients, including patient transitions into and out of the service.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.630 & 430.640
Hist. MHD 8-1994, f. & cert. ef. 11-28-94; MHS 22-2016, f. & cert. ef. 12-1-16

309-032-0890
Variances

(1) Criteria for a variance. Variances may be granted to a regional acute care psychiatric service if implementation of the proposed alternative services, methods, concepts or procedures would result in service or system that meet or exceeds the standards in these rules.

(2) Variance Application. Application for a variance to these or other applicable rules will be obtained pursuant to the process governed by OAR 309-008-1600.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented:
Hist. MHD 8-1994, f. & cert. ef. 11-28-94; MHS 22-2016, f. & cert. ef. 12-1-16

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Rule Caption: Permanent amendments to OAR 309-014 titled Community Mental Health Contractors.
Adm. Order No.: MHS 23-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 10-1-2016
Rules Adopted: 309-014-0021, 309-014-0022, 309-014-0023, 309-014-0036
Rules Amended: 309-014-0000, 309-014-0005, 309-014-0020, 309-014-0025, 309-014-0030, 309-014-0035, 309-014-0037, 309-014-0040, 309-014-0010, 309-014-0015
Subject: These rules prescribe administrative standards for community mental health programs approved by Health Systems Division.
Rules Coordinator: Nola Russell—(503) 945-7652

309-014-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe general administrative standards for Division community mental health programs.

(2) Certificate Required: To receive a certificate for the provision of behavioral health treatment services a Community Mental Health Program must meet the criteria under OAR 309-008-0100 to 309-008-1600; in addition, the Opioid Treatment Program must:

(3) Renewal: The renewal of a Certificate shall be governed by OAR 309-008-0100 to 309-008-1600.

(4) Denial, Revocation, Nonrenewal, Suspension: The denial, revocation, nonrenewal, or suspension of a letter of approval or license for an opioid treatment program may be based on any of the grounds set forth in OAR 309-008-1100.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; MHD 14-1982, f. & ef. 7-7-82, Sections (3) thru (13) Renumbered to 309-014-0005 thru 309-014-0040; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0005
Definitions

As used in these rules:

(1) "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.

(2) "Chief Officer" means the Chief Health Systems Officer of the Oregon Health Authority, or his or her designee.

(3) "CMHP" means "Community Mental Health Program": an entity that is responsible for planning and delivery of safety net services for persons with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse in a specific geographic area of the state under a contract with the Division or a local mental health authority.

(4) "CMHP Program Area" means the organization of all services for persons with either mental or emotional disturbances, drug abuse problems, or alcoholism and alcohol abuse problems, operated by, a local mental health authority, operated in a specific geographic area of the state under a contract with the Division.

(5) "CMHP Director" means the director of a CMHP who operates or contracts for all services for persons with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse problems under the omnibus contract with the Division.

(6) "Community Mental Health Advisory Committee" means the advisory committee to a local mental health authority.

(7) "Division" means the Health Systems Division of the Oregon Health Authority.

(8) "Individual" means a person receiving services under 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 or private corporation.

(9) "Local Revenues" means all money, other than state or federal grant or contract funds, expended by a local mental health authority and any of its subcontractors for community mental health services and included in the approved community mental health contractor plan and budget. However, federal funds expended for alcoholism treatment and rehabilitation services provided under ORS 430.345 to 430.380 in accordance with ORS 430.359(3) by community mental health contractors shall be considered local revenues.

(10) "Omnibus Contract" means the Financial Assistance Grant Agreement or contract between the Health Systems Division and a local mental health authority for all services for persons with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse problems, operated in a specific geographic area.

(11) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services provided by the community mental health contractor.

(12) "Service Element" means a distinct service or group of services for person with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse problems, operated in the community under a contract with the Health Systems Division, or under contract with a local mental health authority.

(13) "Service Provider" means an entity or person that delivers services funded wholly or in part by the Division under a contract with the Division.

(14) "State Institution" means Oregon State Hospital in Junction City and Salem.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(3), MHD 14-1982, f. & ef. 7-7-82; MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00 cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0010
Purpose of a Community Mental Health Program

The purpose of a CMHP is to provide a system of appropriate, accessible, coordinated, effective, efficient safety net services to meet the mental health needs of the citizens of the community.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(4), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0015
Division Responsibility for Community Addictions and Mental Health

The Division shall assist the local mental health authority in establishing and operating community mental health services and shall integrate such services with other mental health system components in the state by:

(1) Assessing needs for community mental health services in the state.

(2) Identifying priorities among needs and preparing state plans for community mental health disability services.

(3) Conducting the Division's activities in the least costly and most efficient manner so that delivery of services to the mentally or emotionally disturbed, alcohol abuser, alcoholic, drug abuser and drug-dependent persons shall be effective, coordinated and integrated with other services within the Oregon Health Authority.

(4) Obtaining resources and contracting with local mental health authorities for the operation of community mental health safety net service.

(5) Subject to the availability of funds, providing public information, program consultation, technical assistance, and training concerning community mental health services.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(4) & (7), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0020
Program Director Qualifications

(1) The CMHP Director shall be a full time employee of the local mental health authority or the public or private corporation operating the community mental health program;

(2) The CMHP Director shall meet the following requirements:

(a) Hold at least a master's degree in a behavioral, social, health science, special education, public administration, or human service administration; and

(b) Have a minimum of five years of experience in human services programs, two of which are in community mental health and two of which are program managerial experience in human services; and

(c) Present references documenting experience, training, and ability to manage a community mental health program.

(3) When the position of community mental health program director becomes vacant, an interim director shall be appointed to serve until a permanent director is appointed.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5), (6), (9), (10) & (12), MHD 14-1982, f. & ef. 7-7-82; MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0021
Management Functions

(1) In addition to other duties as may be assigned in the area of developmental disability services, the CMHP shall, at a minimum, assure the following duties are performed:

(a) Develop plans as may be needed to provide a coordinated and efficient use of resources available to serve people with developmental disabilities;

(b) Develop positive and cooperative working relationships with families, advocates, service providers, the Division, and other state and local agencies with an interest in developmental disability services;

(c) Assure collection and timely reporting of information as may be needed to conduct business with the Division, including but not limited to information needed to license foster homes, to collect federal funds supporting services, and to investigate complaints related to services or suspected individual abuse; and

(2) Management Plan. The CMHP shall maintain a plan assigning responsibility for the management functions and duties described in this section. The community mental health program shall assure that the functions and duties are assigned to people who have the knowledge and experience necessary to perform them.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0022
Contracts

(1) In keeping with the principles of family support expressed in ORS 417.342, and notwithstanding 430.670(2) or 291.047(3), an entity operating a CMHP may purchase services for an individual from a service provider without first providing an opportunity for competition among other service providers if the service provider is selected by the individual, the individual's family or the individual's guardian, as long as the service provider has been approved by the Division to provide such service.

(2) Limit on contract requirements. When a CMHP contracts with a public agency or private corporation for delivery of developmental disability services, the CMHP shall include in the contract only terms that are substantially similar to model contract terms established by the Division. The CMHP may not add contractual requirements, including qualifications for contractor selection, which are nonessential to the service element(s) being provided under the contract. The CMHP shall specify in contracts with service providers that disputes, which arise from these limitations, shall be resolved according to procedures contained in these rules. For purposes of this section, the following definitions apply:

(a) "Model contract terms established by the Division" means all applicable material terms and conditions of the omnibus contract, as modified to appropriately reflect a contractual relationship between the service provider and the CMHP, and any other requirements approved by the Division as local options under procedures established in these rules.

(b) "Substantially similar to model contract terms" means that the terms developed by the CMHP 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 service element(s) being provided" means requirements that are not substantially similar to model contract terms developed by the Division.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0023
The Appeal Process

(1) Notice of Appeal.

(a) If a service provider believes that the contract offered by the CMHP contains terms or conditions that are not substantially similar to those established by the Division in the model contract, the service provider may appeal imposition of the disputed terms or conditions by sending a written notice of appeal to the Division's Chief Officer within 30 calendar days after the effective date of the contract requirement. The notice of appeal shall include:

(A) A copy of the contract and any pertinent contract amendments;

(B) Identification of the specific term(s) that are in dispute; and

(C) A complete written explanation of the dissimilarity between terms.

(D) The service provider shall send a copy of its notice of appeal to the CMHP. Upon receipt of this notice, the CMHP shall suspend enforcement of compliance with any contract requirement under appeal by the contractor until the appeal process is concluded.

(2) The Chief Officer or designee, shall offer to meet with both to mediate a solution. If a solution cannot be mediated, the Chief Officer shall declare an impasse through written notification to all parties and immediately appoint a panel to consider arguments from both parties.

(3)(a) The Mediation Panel The panel shall include, at a minimum, a representative from the Division, a representative from another CMHP, and a representative from another service provider organization.

(b) The panel shall meet with the parties, consider their respective arguments, and send written recommendations to the Chief Officer of the Division within 45 business days after an impasse was declared. If an appeal requiring panel consideration has been received from more than one contractor, the Division may organize materials and discussion in any manner it deems necessary, including combining appeals from multiple contractors, to assist the panel in understanding the issues and operating efficiently.

(c) The Chief Officer shall notify all parties of his/her decision within 15 business days after receipt of the panel's recommendations. The decision of the Administrator is final. The CMHP shall take immediate action to amend contracts as needed to comply with the Administrator's decision.

(3)(a) Expedited Appeal Process. The CMHP 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.

(b) The request shall be made in writing to the Division's Chief Officer. It shall describe the potential harm and level of risk that will be incurred by following the appeal process. The Division shall notify all parties of its decision to approve an expedited appeal process within two business days.

(c) If an expedited process is approved, the Chief Officer shall notify all parties of his/her decision concerning the dispute within three additional business days. The Chief Officer's decision resulting from an expedited appeal process shall be binding, but temporary, pending completion of the appeal process. All parties shall act according to the Chief Officer's temporary decision until notified of a final decision.

(4) Exception to Facility Requirements. The CMHP may add contract requirements that the CMHP considers necessary to ensure the siting and maintenance of residential facilities in which individual care is provided. These requirements shall be consistent with all applicable state and federal laws and regulations related to housing.

(5) Needs Assessment and Planning. The CMHP shall assess local needs for services to persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems. The CMHP shall plan for meeting those needs within the constraints of resources available. The local mental

health authority shall review and approve the plan before it is submitted to the Division.

(6) Monitoring. The local mental health authority shall monitor all CMHP service elements to assure that:

(a) Service elements are provided as specified in the contract with the Division; and

(b) Service elements are in compliance with these rules and other applicable Division administrative rules.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0025
Management of Community Mental Health Program Areas

Each CMHP contractor providing a community mental health program area under a contract with the Division is required to meet the following standards for management:

(1) Organizations:

(a) Each CMHP area contractor shall have an up-to-date organization chart showing the line of authority and responsibility from the local mental health authority to the CMHP area director and to each of the components of the CMHP area contractor;

(b) For all components of the community mental health program area contractor operated by agencies other than the local mental health authority, there shall be a contract between the local mental health authority and the subcontract agency specifying the authorities and responsibilities of each party and conforming to the requirements of any Division rule pertaining to contracts.

(2) Needs Assessment and Planning: When the Division contracts for a CMHP program area, the contractor shall assess local needs for services to persons within that program area, and shall plan to effectively and efficiently meet those needs within the constraints of available resources. The local mental health authority shall review and approve the plan before it is submitted to the Division.

(3) Monitoring: The local mental health authority shall monitor all community mental health service elements within the program area to assure that:

(a) Service elements are provided as specified in the contract with the Division; and

(b) Service elements are in compliance with these rules and other applicable Division administrative rules.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5) & (6), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0030
Management of All Service Elements

All contractors providing community mental health service elements under a contract with the Division are required to meet the following standards for management:

(1) Fee Policy. For all community mental health service elements, except local administration and those provided by a public education district, the agency providing the service element shall:

(a) Determine the cost of each type of service element provided;

(b) Establish a schedule of fees for service elements based on the costs of the service elements, adjusted on the basis of the client's ability to pay;

(c) At the time the service elements is initiated, inform the client of the agency fee policy, the agency fee schedules, and the fee rate to be collected from the client in the event that third party payments do not cover the cost of the client's service elements;

(d) Billings for Title XIX funds shall in no case exceed the customary charges to private clients for any like item or service charged by the service element; and

(e) Charge fees for service elements as follows:

(A) Except where expressly prohibited by federal law or regulation, when third party payments do not cover the full fee for the service elements provided, charge the client or those legally responsible for the cost of the client's care, in an amount which is the lesser of:

(i) The balance of the fee charged to but not paid by the third party payor(s); or

(ii) A fee adjusted on the basis of the client's ability to pay.

(B) Charge any third party payor in the amount of the full fees for the service elements provided. Should the sum of any third party payments and client payments exceed the fee, a refund of the excess payment shall be given to the client.

(2) Quality Assurance. Each provider of community mental health and developmental disability service elements shall implement and maintain a quality assurance program.

(3) Internal Management. Each provider of CMHP service elements funded by the Division shall meet the following internal management standards:

(a) There shall be an up-to-date organization chart showing lines of authority and responsibility for the services within the agency;

(b) There shall be up-to-date, written position descriptions for all staff providing community mental health and developmental disability services;

(c) If four or more staff provide CMHP services, there shall be written personnel policies and procedures concerning:

(A) Recruitment and termination of employees;

(B) Compensation plan;

(C) Performance appraisals, promotions and merit increases, and staff development;

(D) Employee benefits; and

(E) Grievance procedures.

(d) Each employee providing CMHP services shall have the opportunity for in-service training with pay;

(e) There shall be up-to-date accounting records for each mental health service element accurately reflecting all revenue by source, all expenses by object of expense, and all assets, liabilities, and equities, consistent with generally accepted accounting principles and conforming to the requirements of OAR 309-013-0120 to 309-013-0220;

(f) There shall be written statements of policy and procedure as are necessary and useful to assure compliance with any administrative rule pertaining to fraud and embezzlement and abuse of patients, residents, and clients; and

(g) There shall be such other written statements of policy and procedure as are necessary and useful to enable the agency to accomplish its mental health service objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5) & (6), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0035
Delivery of CMHP Service Elements

All community mental health contractors providing community mental health service elements under a contract with the Division are required to meet the following general standards for delivery of community mental health service elements:

(1) Eligibility for Service:

(a) In accordance with the Civil Rights Act of 1964, community mental health services shall not be denied any person on the basis of race, color, creed, sex, national origin or duration of residence. Community mental health contractors shall also comply with Section 504 of the Rehabilitation Act of 1973 as implemented by 45 CFR 84.4, which states in part, "No qualified person shall, 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 which receives or benefits from federal financial assistance";

(b) No person shall be denied services or be discriminated against on the basis of age or diagnostic or disability category unless predetermined clinical or program criteria for service restrict the service to specific age or diagnostic groups or disability category;

(c) No person shall be denied community mental health services based on ability to pay;

(d) Any person eligible for community mental health services provided by one agency shall also be eligible for other CMHP services provided by any other agency, unless admission to the service is subject to diagnostic or disability category or age restrictions based on predetermined criteria.

(2) Continuity and Coordination:

(a) Each agency providing community mental health services shall make pertinent clinical and financial eligibility information concerning a client of the agency readily available to other community mental health service agencies responsible for the client's care, consistent with state statutes and federal laws and regulations concerning confidentiality;

(b) In the event that a person seeking or receiving services from one community mental health contractor requires services not provided by the

contractor, the person shall be referred to an available appropriate agency which can provide the needed services;

(c) Planning and implementation of service for clients of the community mental contractor shall be coordinated between components of the community mental health and developmental disability contractor, and other human service agencies, and between components of the community mental health contractor and state institutions. Each CMHP or community mental health program area contractor shall maintain a written agreement with state institutions serving the county. The agreement shall include, but need not be limited to:

(A) The procedures to be followed to assure necessary communication between the state institution and the community mental health program or CMHP area contractor when a client is admitted to, and discharged from, the state institution and during the period of care, treatment or training;

(B) The type of client information which will be shared by the CMHP area contractor and the state institution, the manner in which the information will be transmitted and the times when such information will be provided;

(C) The names of the staff members from the state institution and the CMHP area contractor, who will have principal responsibility for liaison and implementation of the agreement; and

(D) Each agreement between the state institution and a CMHP, or program area contractor, shall be reviewed and renewed at least once a year.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(8) & (11), MHD 14-1982, f. & ef. 7-7-82 ; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0036
Records

(1) Service Records. A record shall be maintained for each client who receives direct treatment training and/or care services. The record shall contain client identification, problem assessment, treatment, training and/or care plan, medical information when appropriate; and progress notes.

(2) Retention of Records. Records shall be retained in accordance with OAR 166-005-0000 through 166-040-0010 (State Archivist). Financial records, supporting documents, statistical records, and all other records (except client records) shall be retained for a minimum of three years after the close of the contract period, or until audited. Client records shall be kept for a minimum of seven years.

(3) Confidentiality of Client Records. Client records shall be kept confidential in accordance with ORS 179.505, 45 CFR 205.50 and 42 CFR Part 2, any Division administrative rule pertaining to client records, and the most current edition of the Division Handbook on Confidentiality.

(4) Client Rights. Each agency providing any community mental health service shall have written procedures to assure:

(a) Protection of client privacy and dignity;

(b) Confidentiality of records consistent with state statutes and federal statutes and regulations;

(c) Involvement of the client in planning the service through the provision of information, presented in general terms, which explains the following:

(A) The treatment to be undertaken;

(B) Alternative treatment methods available, if any; and

(C) Risks that may be involved in the training or treatment, if any.

(d) Client's right to refuse service unless otherwise ordered by a court; and

(e) Client is provided with information, presented in general terms, concerning the agency fee policies.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0037
Dispute Resolution

(1) The CMHP shall adopt a dispute resolution policy that pertains to disputes that may arise from contracts with service providers that deliver services funded by the Division for the CMHP. Procedures implementing this policy shall be included in the contract with any such service provider.

(2) When a dispute exists between a county or a CMHP and a service provider regarding the terms of their contract or the interpretation of an administrative rule of the Division relating to Division programs under ORS Chapter 430, and local dispute resolution efforts have been unsuccessful, either party may request assistance from the Division in mediating the dispute.

(a) Procedure. The parties shall demonstrate a spirit of cooperation, mutual respect, and good faith in all aspects of the mediation process. Mediation shall be conducted as follows:

(A) Request. The party requesting mediation shall send a written request to the Division Chief Officer, the CMHP director, and the provider agency director, unless other persons are named as official contact persons in the specific rule or contract under dispute. The request shall describe the nature of the dispute and identify the specific rule or contract provisions that are central to the dispute.

(B) Arrangements. The Chief Officer or designee, shall arrange the first meeting of the parties at the earliest possible date. The agenda for the first meeting should include:

(i) Consideration of the need for services of an outside mediator. If such services are desired, agreement should be made on arrangements for obtaining these services.

(ii) Development of rules and procedures that will be followed by all parties during the mediation;

(iii) Agreement on a date by which mediation will be completed, unless extended by mutual agreement.

(C) Cost. 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) Final Report. A written statement documenting the outcome of the mediation shall be prepared. This statement shall 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 Division representative shall prepare the final report. The final report on each mediation shall be retained on file at the Division. The Division will, from time to time, or as requested by the legislature or others, prepare summary reports that describe the success of mediation in resolving disputes.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

309-014-0040
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 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.

(4) A variance granted by the Division shall be attached to, and become part, of the contract for that year.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.640
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(13), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00; MHS 23-2016, f. & cert. ef. 12-1-16

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Rule Caption: New rules regarding the communication protocol and post-intervention protocol to address suspected youth suicide.
Adm. Order No.: MHS 24-2016
Filed with Sec. of State: 12-5-2016
Certified to be Effective: 12-5-16
Notice Publication Date: 10-1-2016
Rules Adopted: 309-027-0010, 309-027-0020, 309-027-0030, 309-027-0040, 309-027-0050, 309-027-0060
Subject: These rules implement Senate Bill (SB) 561 from Oregon's 2015 Regular Session. The rules identify Local Mental Health Authorities as the entities responsible for initiating and coordinating the community response to each case of suicide which meets the criteria established in SB 561.
Rules Coordinator: Nola Russell—(503) 945-7652

309-027-0010
Purpose and Scope

(1) These rules implement Senate Bill (SB) 561 from Oregon's 2015 Regular Session. The rules identify Local Mental Health Authorities (LMHAs) as the entities responsible for initiating and coordinating the community response to each case of suicide which meets the criteria established in SB 561. There are three purposes for the rules:

(a) The rules establish minimum standards for the communication protocol and post-intervention protocol to address suspected youth suicide.

(b) The rules aim to reduce the risk of contagion among individuals 24 years of age or younger after a suspected youth suicide by establishing overall guidelines for communication and post-intervention response protocols for effective communication and response by local agencies, groups, or individuals .

(c) The rules establish the process for LMHAs to report suspected youth suicides to the Oregon Health Authority within seven (7) days of the death.

(2) The Oregon Health Authority shall provide technical assistance to LMHAs in developing and implementing the protocols and reporting of suspected youth suicides.

Stat. Auth.: ORS 413.042, 430.630, 430.634, 430.640
Stats. Implemented: ORS 418.735
Hist.: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0020
Definitions

(1) "Authority" means the Oregon Health Authority (OHA).

(2) "Communication Protocol" means the plan identifying information-sharing pathways to improve notifications and information-sharing regarding a suspected youth suicide between the LMHA and community partners, and the individuals within those entities to communicate or receive communications.

(3) "Community partners" includes local individuals, entities, and organizations including medical examiners, public school districts, public universities, private post-secondary institutions of education, or any facility or organization that provides services or resources to runaway or homeless youth.

(4) "Coordinator" means the Authority's Suicide Intervention and Prevention Coordinator or his or her designee.

(5) "LMHA" means a Local Mental Health Authority as defined in ORS 430.630.

(6) "Medical examiner" has the same meaning given that term in ORS 146.003(10) or a physician appointed as provided by ORS 146.003 to 146.189 to investigate and certify the cause and manner of deaths requiring investigation, including the State Medical Examiner.

(7) "Authority's Plan" means the Authority's Youth Suicide Communication and Post-Intervention Plan developed to implement SB 561 codified as ORS 418.735.

(8) "Post-Intervention" or "Postvention" means the activities implemented after a suspected youth suicide, including support for the bereaved family, friends, professionals, peers and those with geographic, social or social media ties to the deceased. "Post-intervention and "postvention" are used interchangeably. In order to meet the needs of those bereaved by a suicide, and to reduce the risk of contagion "post-intervention" includes:

(a) Immediate postvention response implemented in the immediate days and weeks after a suspected youth suicide;

(b) Intermediate postvention response implemented in the several months after a suspected youth suicide; and

(c) Long-term postvention response implemented up to a year after the suspected youth suicide.

(9) "Primary LMHA" means the LMHA serving the county where the suspected youth suicide occurred.

(10) "Response Protocol" means the plan identifying the roles, responsibilities and actions of the LMHA and community partners that are activated in response to a suspected youth suicide.

(11) "Suicide Contagion" means the exposure to the suicide or suicidal behavior of one or more persons that influences others to engage in suicidal behavior, including to attempt or complete suicide.

(12) "Suspected Youth Suicide" means a death of an individual 24 years of age or younger reported by a medical examiner or designee that is believed to have been caused by self-directed injurious behavior with an intent to die as a result of the behavior.

(13) "Traumatic Death" means a death that is sudden, unanticipated, violent, mutilating or destructive, random and/or preventable, involves multiple deaths, or one in which the mourner has a personal encounter with death. It may be caused by an accident, homicide, suicide or death in war.

Stat. Auth.: ORS 413.042, 430.630, 430.634, 430.640
Stats. Implemented: ORS 418.735
Hist.: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0030
Communication Protocol

(1) Each LMHA, in collaboration with community partners, shall identify local pathways for information-sharing and shall establish a Communication Protocol to communicate across and within the LMHA and community partners to inform and mobilize post-intervention response.

(2) Communication Protocols shall, at the minimum:

(a) Identify the community partners involved in developing and implementing the protocol;

(b) Identify the specific roles and responsibilities of the LMHA and community partners for implementing the protocol;

(c) Identify how a Lead Communication Person will be identified for responding to each suspected youth suicide. The Lead Communication Person may vary among incidents, depending on the nature of the death, location of the death, age of the decedent, or other factors. The Lead Communication person may be an individual designated by a school district or university, the LMHA, another facility, or another community partner. The Lead Communication Person is responsible for centralizing information-sharing activities in the event of a suspected youth suicide;

(d) Detail the communication-sharing process among community partners; and

(e) Identify the specific information and data that will be communicated between and across the community partners. This may vary, depending on the role or responsibilities of each partner and applicable law.

(3) The LMHA shall document the completed Communication Protocol in writing and submit to the Coordinator within 120 days of the effective date of these rules.

(4) At least annually each LMHA, in collaboration with community partners, shall review the Communication Protocol and evaluate the protocol's effectiveness over the past year, and provide a rationale for all revisions to the Coordinator.

(5) The Coordinator shall:

(a) Review the communication protocols submitted by the LMHAs;

(b) Review any revisions to the communication protocols as submitted annually; and

(c) Provide feedback to the LMHA, including information on best practices, and offer technical assistance for preparation and implementation of the protocols.

Stat. Auth.: ORS 413.042, 430.630, 430.634, 430.640
Stats. Implemented: ORS 418.735
Hist.: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0040
Response Protocol

(1) Each LMHA, in collaboration with community partners, shall develop a Response Protocol identifying community partners, programs, individuals and others within the community that may be mobilized to provide post-intervention response to a suspected youth suicide.

(2) At minimum, the Response Protocol shall:

(a) Identify the community partners involved in developing and implementing the Response Protocol;

(b) Identify the roles, responsibilities, services, and available resources of each community partner involved in implementing the Response Protocol including the immediate, intermediate and long-term postvention response.

(c) Identify how a Lead Response Person shall be identified for responding to each suspected youth suicide. The Lead Response Person may vary, depending on the circumstances and may be an individual designated by a school district or university, the LMHA, or another community partner. The Lead Response Person is responsible for coordinating post-intervention response in the event of a suspected youth suicide. The Lead Response Person for the Response Protocol also may be the Lead Communication Person.

(d) Establish and detail the post-intervention response process among community partners, including outreach to families and families of choice; and

(e) Identify the evaluation process used by community partners to debrief and assess the effectiveness of each suspected youth suicide response and the mechanism to adjust processes, as indicated, in the future. The evaluation process shall include an assessment of the effectiveness of meeting the needs of grieving families and families of choice; friends or others with relationships with the deceased; and the wider network of community members impacted by the suspected youth suicide.

(f) Identify how the Primary LMHA will notify other LMHAs linked to the deceased through residency, employment, school attendance, or significant family or social ties.

(3) The LMHA shall document the completed Response Protocol in writing and submit to the Coordinator.

(4) At least annually each LMHA in collaboration with community partners shall review the Response Protocol to debrief and evaluate the protocol's effectiveness in the past year, and provide a rationale for all revisions to the Coordinator.

(5) For the purposes of Response Protocols, the Coordinator shall:

(a) Review the response protocols submitted by the LMHAs;

(b) Review any revisions to the response protocols submitted annually; and

(c) Provide feedback to the LMHA and offer technical assistance on best practices for development and implementation of the protocols.

Stat. Auth.: ORS 413.042, 430.630, 430.634, 430.640
Stats. Implemented: ORS 418.735
Hist.: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0050
Technical Assistance

As part of the Authority's plan for communication and response coordination among LMHAs and community partners, the Authority shall provide technical assistance for developing and updating protocols, including Coordinator assistance through:

(1) Providing comments regarding best practices to LMHAs on the content of communication and response protocols;

(2) Providing technical assistance regarding best practices in preparing the protocols;

(3) Providing technical assistance on best practices in implementing the protocols; and

(4) Providing technical assistance on best practices in responding to suspected youth suicides. This may include telephone assistance on a case by case basis, general information in the form of publications, web content, presentations or webinars.

Stat. Auth.: ORS 413.042, 430.630, 430.634, 430.640
Stats. Implemented: ORS 418.735
Hist.: MHS 24-2016, f. & cert. ef. 12-5-16

309-027-0060
Reporting To Coordinator

(1) Each LMHA shall designate a Designated Reporter assigned to timely report suspected youth suicides and postvention activities to the Coordinator. Each LMHA shall provide the name and all contact information (including email address and phone number) for the Designated Reporter. The LMHA shall also designate a backup Designated Reporter to assume those responsibilities in the event of the Youth Suicide Reporter's absence. The LMHA shall maintain updated contact information of the Designated Reporter and backup with the Coordinator.

(2) Within seven (7) days of a suspected or confirmed youth suicide the primary LMHA shall report to the Coordinator as follows or to the extent allowed by law.

(3) The LMHA in the county where the death occurred shall report the death to the Coordinator. The Primary LMHA and each impacted LMHA shall report their respective postvention activities. At a minimum, the reports to OHA shall include:

(a) Date of report;

(b) The author's name, affiliated LMHA, email address and phone number;

(c) The date of the suspected youth suicide and the city and county in which the suspected youth suicide occurred;

(d) Age of the decedent;

(e) If a student, the name of the school, public or private university or college, or private post-secondary institution of education attended by the deceased.

(f) A narrative discussing the postvention activities completed or to be completed by the Primary LMHA, other impacted LMHAs, if available, and community partners. The narrative must include activities completed or planned for:

(A) The immediate postvention response;

(B) The intermediate postvention response; and

(C) The long-term postvention response, including how the interventions may change due to the end of a school year, at graduation, and at the anniversary of the death.

(g) If the LMHA has not determined intermediate or long-term postvention response activities at the time of the seven- day report, the LMHA shall provide the narrative described in subsection (f) to the Coordinator within 45 days of the date of the initial report.

(h) A request or decline of technical assistance from OHA.

(i) If assistance is requested, the LMHA shall make the request by phone or secure email and include as much of the following as is possible:

(A) The decedent's age; race and/or ethnicity; gender; gender identify; and sexual orientation;

(B) Identify the agency with custody of the decedent, if applicable;

(C) Identify organizations or individuals that provided services or resources to the decedent if the decedent was a runaway or homeless youth at the time of death;

(D) Location of the suspected youth suicide (such as a public place or private residence);

(E) Any evidence of bullying (cyber or in person);

(F) The manner in which, if at all, social media were involved;

(G) Whether, within the previous year, the decedent's family experienced another suicide;

(H) A description of all other traumatic deaths within the community, if known within the previous year; and

(I) Whether the decedent was receiving mental or behavioral health services at or close to the time of death.

(4) LMHAs shall notify the Coordinator if a death reported as a suspected youth suicide is later determined by the medical examiner or designee to not be a suicide.

(5) OHA shall provide LMHAs with a form for reporting the required information via e-mail to the Coordinator.

(6) Each LMHA shall annually report to the Coordinator an assessment of the effectiveness of the: communication and response protocols; post-intervention services provided, and procedures for reporting deaths to OHA. The LMHA may also include an estimate of the costs to the LMHA in implementing these rules that year.

(7) As part of the Authority's Plan to improve communication and response to suspected youth suicides, the Coordinator shall use the information compiled from the LMHA annual reports to aid its efforts to serve as a resource to the LMHAs.

Stat. Auth.: ORS 413.042, 430.630, 430.634, 430.640
Stats. Implemented: ORS 418.735
Hist.: MHS 24-2016, f. & cert. ef. 12-5-16

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Oregon Health Authority, Public Health Division
Chapter 333

Rule Caption: Amend Certification Requirements for Local School Dental Sealant Programs
Adm. Order No.: PH 32-2016
Filed with Sec. of State: 11-18-2016
Certified to be Effective: 11-18-16
Notice Publication Date: 10-1-2016
Rules Amended: 333-028-0320
Subject: The Oregon Health Authority (OHA), Public Health Division, Oral Health Program is permanently amending OAR 333-028-0320, "Certification Requirements" in chapter 333, division 28 "Certification for Local School Dental Sealant Programs" to clarify certification requirements in sections (4) and (6). These changes are clarifications only and not a change to the existing rule.
Rules Coordinator: Brittany Hall—(971) 673-1291

333-028-0320
Certification Requirements

To be certified, a Local School Dental Sealant Program must meet all requirements for certification.

(1) A representative responsible for coordinating and implementing the Local School Dental Sealant Program must attend a one-time certification training provided by the Program. If the Local School Dental Sealant Program experiences personnel changes that impact the representative responsible for coordinating and implementing the Local School Dental Sealant Program, then a new representative must attend the one-time certification training before applying for recertification. Any templates or materials provided by the Program during the certification training that are modified or utilized by the Local School Dental Sealant Program must acknowledge the Program on such templates or materials.

(2) A Local School Dental Sealant Program must provide an annual clinical training to all providers rendering care within their scope of prac-

tice in a school setting. This requirement may be met by one of these methods:

(a) A Local School Dental Sealant Program develops and implements its own training.

(b) A Local School Dental Sealant Program sends their providers to an annual training provided by the Program.

(3) Before initially contacting any school to offer services, a Local School Dental Sealant Program must contact the Coordinated Care Organizations (CCOs) operating in the community. In consultation with the Program, the CCO will determine which Local School Dental Sealant Program is best able to provide services. A CCO must contact the Program before any decision is made. This collaboration will ensure access and minimize the duplication of services. Priorities should be given to the most cost-effective dental sealant delivery model that meets certification requirements. Existing relationships with schools and providers should be considered when multiple delivery models meet requirements. The Program will provide the CCOs with a list of school dental sealant programs and the schools they serve from the Certification Application and Renewal Certification Application forms.

(4) A Local School Dental Sealant Program must ensure Medicaid encounters for dental sealants are entered into the Medicaid system.

(5) A Local School Dental Sealant Program shall first target elementary and middle schools where 40 percent or greater of all students attending the school are eligible to receive assistance under the United States Department of Agriculture's National School Lunch Program.

(6) A Local School Dental Sealant Program must offer, at a minimum, dental sealant services to students regardless of insurance status, race, ethnicity or socio-economic status in these grade levels:

(a) Elementary school students in first and second grades or second and third grades; and

(b) Middle school students in sixth and seventh grades or seventh and eighth grades.

(7) A Local School Dental Sealant Program must develop and implement a plan to increase parental/guardian permission return rates.

(8) A Local School Dental Sealant Program must adhere to these standards for school dental sealant programs:

(a) Dental equipment must be used on school grounds during school hours;

(b) A medical history is required on the parent/guardian permission form;

(c) Use the four-handed technique to apply sealants in elementary schools;

(d) Use the two-handed technique using an Isolite or equivalent Program approved device or the four-handed technique to apply sealants in middle and high schools; and

(e) Apply resin-based sealants.

(9) A Local School Dental Sealant Program must comply with all scope of practice laws as determined by the Oregon Board of Dentistry.

(10) A Local School Dental Sealant Program must comply with Oregon Board of Dentistry oral health screening guidelines.

(11) A Local School Dental Sealant Program must comply with infection control guidelines established in OAR 818-012-0040.

(12) A Local School Dental Sealant Program must comply with the Health Insurance Portability and Accountability Act (HIPAA) and Federal Educational Rights and Privacy Act (FERPA) requirements.

(13) A Local School Dental Sealant Program must respect classroom time and limit demands on school staff. Services must be delivered efficiently to ensure a child's time out of the classroom is minimal.

(14) A Local School Dental Sealant Program must conduct retention checks at one year for quality assurance.

(15) A Local School Dental Sealant Program must submit a data report to the Program annually. The information required to be included in such data report will be defined by the Program. Aggregate-level data will be required for each school.

(16) A Local School Dental Sealant Program must include the certification logo provided by the Program on all parent/guardian permission forms and written communication to schools, or provide schools with a letter provided by the Program indicating the Local School Dental Sealant Program is certified.

Stat. Auth.: ORS 431A.725
Stats. Implemented: ORS 431A.725
Hist. : PH 2-2016, f. & cert. ef. 1-29-16; PH 32-2016, f. & cert. ef. 11-18-16

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Rule Caption: Marijuana Labeling; Medical Marijuana Growers, Processors, Dispensaries and Cards

Adm. Order No.: PH 33-2016
Filed with Sec. of State: 11-28-2016
Certified to be Effective: 11-28-16
Notice Publication Date: 10-1-2016
Rules Adopted: 333-008-1255
Rules Amended: 333-007-0010, 333-007-0090, 333-007-0100, 333-007-0200, 333-007-0210, 333-007-0220, 333-007-0300, 333-008-0010, 333-008-0023, 333-008-0040, 333-008-0600, 333-008-1020, 333-008-1110, 333-008-1200, 333-008-1230, 333-008-1500, 333-008-1505, 333-008-1620, 333-008-1730, 333-008-1740, 333-008-1760, 333-008-1770, 333-008-1820, 333-008-2080, 333-008-2120, 333-008-2190, 333-008-9900
Rules Repealed: 333-008-1190, 333-008-1225, 333-008-2130, 333-007-0010(T), 333-007-0100(T), 333-008-1200(T), 333-008-1740(T), 333-008-1230(T), 333-008-1500(T), 333-008-1505(T)
Subject: The Oregon Health Authority, Public Health Division, Oregon Medical Marijuana Program is adopting new regulations and amending Oregon Administrative Rules in chapter 333, division 7 and 8.

These rules will incorporate changes made to the Oregon Medical Marijuana Act from the 2016 legislative session by establishing standards non-profit dispensaries will need to meet in order to operate as a non-profit, and by removing the requirement for veterans with total and permanent disability or 100% disability ratings to submit an attending physician signature form each time they renew their patient card.

This rulemaking permanently adopts rule amendments pertaining to limited marijuana retail sales and reporting requirements. Housekeeping changes related to marijuana labeling and medical marijuana growers, processors, dispensaries and registry identification cardholders are also a part of this rulemaking.

This rulemaking also permanently adopts rule amendments that change the compliance date for when processors need to be registered with the Oregon Health Authority and dispensaries need to be licensed by the Department of Agriculture from October 1, 2016 to January 1, 2017.
Rules Coordinator: Brittany Hall—(971) 673-1291

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.

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; PH 27-2016(Temp), f. & cert. ef. 9-30-16 thru 3-1-17; PH 33-2016, f. & cert. ef. 11-28-16

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; and

(c) May:

(A) Use a peel-back or accordion label with the information required in subsection (4)(b) of this rule, if the peel-back or accordion label can be easily identified by a patient or consumer as containing important information.

(B) Use 6 point font for the information listed in paragraph (4)(a)(A) to (D) of this rule.

(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."

(15) A cartridge containing a cannabinoid concentrate, extract or product intended for use with an inhalant delivery system as that is defined in ORS 431.840 is not required to be labeled in accordance with these rules except that the cartridge must have a label with the universal symbol. All the remaining label requirements must be included on the packaging that is used to display the cartridge for sale or transfer.

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; PH 33-2016, f. & cert. ef. 11-28-16

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) 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.610
Stats. Implemented: ORS 475B.610
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; PH 27-2016(Temp), f. & cert. ef. 9-30-16 thru 3-1-17; PH 33-2016, f. & cert. ef. 11-28-16

333-007-0200
Concentration and Serving Size Limits: Definitions, Purpose, Scope and 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) OAR 333-007-0200 through 333-007-0220 apply 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 under ORS 475B.630.

(3) 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.

(4) 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.

(5) A marijuana item received or transferred by a dispensary must meet the concentration and serving size limits in OAR 333-007-0220 and until January 1, 2017, OAR 333-008-1500.

(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; PH 33-2016, f. & cert. ef. 11-28-16

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 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; PH 33-2016, f. & cert. ef. 11-28-16; PH 33-2016, f. & cert. ef. 11-28-16

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 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; PH 33-2016, f. & cert. ef. 11-28-16

333-007-0300
Marijuana Testing: 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.

(c) Immature plants or seeds.

(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 that is not sampled and tested in accordance with these rules; or

(b) Accept the transfer of a marijuana item 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.

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; PH 33-2016, f. & cert. ef. 11-28-16

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) "Common ownership" means any commonality between individuals or legal entities named as applicants or persons with a financial interest in a registration or a business proposed to be registered.

(15) "Conviction" means an adjudication of guilt upon a verdict or finding entered in a criminal proceeding in a court of competent jurisdiction.

(16) "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.

(17) "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.

(18) "Delivery" has the meaning given that term in ORS 475B.410.

(19)(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.

(20) "Direct interest" means an interest that is held in the name of the individual.

(21) "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.

(22) "Elementary school" means a learning institution containing any combination of grades Kindergarten through 8.

(23) "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.

(24) "Food stamps" means the Supplemental Nutrition Assistance Program as defined and governed by ORS 411.806 through 411.845.

(25) "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.

(26) "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.

(27) "Grow site registration card" means a card issued by the Authority that identifies the address of a marijuana grow site and the PRMG.

(28) "Immature marijuana plant" means a marijuana plant that is not flowering.

(29) "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.

(30) "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.

(31) "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.

(32) "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.

(33)(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.

(34) "Marijuana item" means marijuana, cannabinoid concentrates, cannabinoid extracts, medical cannabinoid products, and immature marijuana plants.

(35) "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.

(36) "Mature marijuana plant" means a marijuana plant that is not an immature marijuana plant.

(37)(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.

(38) "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.

(39) "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.

(40) "Minor" means an individual under the age of 18.

(41) "Oregon Health Plan (OHP)" means the medical assistance program administered by the Authority under ORS chapter 414.

(42) "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.

(43) "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.

(44) "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.

(45) "Patient" has the same meaning as "registry identification cardholder."

(46) "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.

(47) "Person responsible for a marijuana grow site," or "PRMG" means 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, who has been registered as a PRMG by the Authority under OAR 333-008-0033.

(48) "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.

(49) "Point of sale" means a specific location within a point of sale area at which the transfer of a marijuana item occurs.

(50) "Point of sale area" means a secure area where a registered dispensary transfers a marijuana item to a patient or caregiver.

(51) "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.

(52) "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.

(53) "Process" means the compounding or conversion of marijuana into medical cannabinoid products, cannabinoid concentrates or cannabinoid extracts.

(54) "Production" or "growing" means:

(a) Planting, cultivating, growing, trimming or harvesting marijuana; or

(b) Drying marijuana leaves or flowers.

(55) "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.

(56) "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.

(57) "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.

(58) "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.

(59) "Resident" means an individual who has primary domicile within this state.

(60) "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.

(61) "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.

(62) "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.

(63) "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.

(64) "These rules" means OAR 333-008-0010 to 333-008-0750.

(65) "THC" means tetrahydrocannabinol.

(66)(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.

(67) "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.

(68) "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.

(69) "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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-0023

Patient Application Review Process

(1) The Authority must review a patient application to determine if it is complete.

(2) If an applicant does not provide all the information required in OAR 333-008-0020(1) or pay the applicable fee the Authority will reject the application as incomplete.

(3) If an applicant does not provide all the information required in OAR 333-008-0020(2) and (3), the Authority must notify the applicant of the information that is missing and allow the applicant 14 calendar days to submit the missing information.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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; PH 33-2016, f. & cert. ef. 11-28-16

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, except as provided in section (2) of this rule; and

(c) The additional information and fees required in OAR 333-008-0020.

(2) A patient who meets the following criteria and provides documentation of meeting the criteria in accordance with instructions on the renewal application form is not required to submit an APS as described in subsection (1)(b) of this rule:

(a) Has been assigned a total and permanent disability rating for compensation that rates the veteran as unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities as described in 38 C.F.R. 4.16; or

(b) Has a United States Department of Veterans Affairs total disability rating of 100 percent as a result of an injury or illness that the veteran incurred, or that was aggravated, during active military service and who received a discharge or release under other than dishonorable conditions.

(3) 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.

(4) Between 60 to 90 calendar days prior to expiration, the Authority shall notify the patient of the upcoming expiration date.

(5) 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.

(6) 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.

(7) 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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-0600

PRMG Labeling, Packaging and Testing Requirements

On and after October 1, 2016, a PRMG who transfers usable marijuana to a registered processing site or dispensary must comply with the labeling, packaging and testing requirements in OAR 333-007-0300 to 333-007-0490.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1020

Medical Marijuana Dispensaries: 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.

(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 required under section (3) of this rule 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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1110

Medical Marijuana Dispensaries: 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 the limited access 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 scaled floor plan required in OAR 333-008-1020.

(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) An applicant or registrant may request, in writing, an exception from the Authority from the requirement under subsection (a) of this section 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.

(c) 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.

(d) 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, except a registered processing site under common ownership.

(16) If a dispensary premises is located in a building or structure that includes residential, industrial, agricultural or other commercial uses, occupancies or tenant space, the dispensary premises and any other use, occupancy or tenant space must be completely separate with no communication of space or means of ingress or egress between the dispensary premises and any other use, occupancy or tenant space, except as follows:

(a) A dispensary may share a premises with a registered marijuana processing site that is under common ownership, in accordance with section (17) of this rule and OAR 333-008-2080.

(b) A dispensary is permitted to have a door from the dispensary premises that opens into a common space shared by other commercial uses, occupants, tenants or the public, but that is not exclusively under the control or possession of a single other commercial use, occupancy or tenancy, in accordance with section (17) of this rule.

(17) If a dispensary premises is located in a building or structure that includes residential, industrial, agricultural or other commercial uses, occupancies or tenant space and under section (16) of this rule ingress or egress is permitted, every means of ingress and egress must be:

(a) Through a door that is locked at all times, when not in immediate use, by a commercial grade lock, and that does not permit access by the public.

(b) Posted with signage in accordance with OAR 333-008-1205, as applicable.

(c) Equipped with security and surveillance system coverage in accordance with OAR 333-008-2080 and 333-008-2100.

(18) Residential occupancy of a dispensary premises is prohibited.

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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1200

Medical Marijuana Dispensaries: 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, including review of testing results prior to accepting transfers of marijuana items;

(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. 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 or that has failed a test under OAR 333-007-0450.

(b) Transfer a marijuana item that has not been tested in accordance with OAR 333-007-0300 to 333-007-0490 or that has failed a test under OAR 333-007-0450 unless it was transferred to the dispensary prior to October 1, 2016 and is labeled in accordance with OAR 333-007-0300(5).

(c) Transfer a marijuana item that was received prior to October 1, 2016, that has not been tested in accordance with OAR 333-007-0300 to 333-007-0490, after December 31, 2016.

(8) Packaging and Labeling. 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 January 1, 2017, 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; PH 26-2016(Temp), f. & cert. ef. 9-9-16 thru 3-7-17; PH 27-2016(Temp), f. & cert. ef. 9-30-16 thru 3-1-17; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1230

Medical Marijuana Dispensaries: 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) Beginning October 1, 2016, until January 1, 2017, a registered dispensary may accept the transfer of a medical cannabinoid product or concentrate from an applicant that has submitted a complete application for registration of a marijuana processing site.

(b) On and after January 1, 2017, a registered dispensary may only accept a transfer of a medical cannabinoid product, concentrate or extract from a registered medical marijuana processing site.

(c) Beginning October 1, 2016, until January 1, 2017, a registered dispensary may accept the transfer of a medical cannabinoid extract from an applicant that has submitted a complete application for registration of 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, on a form prescribed by the Authority, 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;

(F) The harvest or process lot numbers, and batch numbers; and

(G) The amount 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.

(c) Review laboratory testing results and confirm that the:

(A) Test results are associated with the marijuana items being transferred; and

(B) Marijuana item has passed all required testing.

(5) Nothing in these rules requires a dispensary registrant to accept a transfer of a marijuana item.

(6) 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; PH 26-2016(Temp), f. & cert. ef. 9-9-16 thru 3-7-17; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1255

Medical Marijuana Dispensaries: Non-Profit Dispensaries

(1) A registered dispensary owned by a nonprofit corporation organized under ORS chapter 65, registered with the Secretary of State as a nonprofit organization, and registered with the Oregon Department of Justice as a charitable organization, if applicable, may receive by gift, devise or bequest:

(a) Usable marijuana, immature marijuana plants and seeds from patients, designated primary caregivers, PRMGs, persons who hold a producer license under ORS 475B.070 and persons who hold a research certificate under ORS 475B.235; and

(b) Medical cannabinoid products, cannabinoid concentrates and cannabinoid extracts from persons responsible for marijuana processing sites, persons who hold a processor license under ORS 475B.090 and persons who hold a research certificate under ORS 475B.235.

(2) Prior to accepting a gift, devise, or bequest as described in section (1) of this rule a registered dispensary owned by a nonprofit corporation must:

(a) Provide the Authority with proof that the dispensary is owned by a nonprofit corporation organized under ORS chapter 65;

(b) Have written policies and procedures for providing free or discounted marijuana items to a patient with an annual income at or below the federal poverty guidelines or to such a patient's designated primary caregiver, that include but are not limited to:

(A) How the dispensary will determine a patient's eligibility for free or discounted marijuana items;

(B) Whether marijuana items will be provided free of charge or at a discounted price; and

(C) How the dispensary will determine who is eligible for free marijuana items and who is eligible for discounted marijuana items, as applicable.

(c) Post a sign at the entrance to the dispensary that reads: Nonprofit Dispensary – Free or Discounted Marijuana Items Available for Eligible OMMP Patients.

(d) Post a sign that can easily be seen at every point of sale that describes:

(A) The proof a patient or a patient's designated primary caregiver must provide to be eligible for free or discounted marijuana items; and

(B) What marijuana items are free or available at a discounted price to eligible patients.

(3) In addition to the record keeping requirements in OAR 333-008-1230, 333-008-1245, and 333-008-1247, a dispensary owned by a nonprofit corporation organized under ORS chapter 65 must specifically document:

(a) The receipt of a marijuana item that is a gift, devise or bequest; and

(b) The transfer of a marijuana item to a patient or a patient's designated primary caregiver free or at a discounted price because the patient has an annual income at or below the federal poverty level, and the proof of income provided to the dispensary by the patient or the patient's designated primary caregiver.

(4) A registered dispensary owned by a nonprofit corporation organized under ORS chapter 65 must provide to the Authority at the time a renewal application is submitted a report that shows:

(a) The amount or number of marijuana items, by type, received by gift, devise or bequest;

(b) The amount or number of marijuana items received by gift, devise or bequest by each registration, license, or certificate type;

(c) The amount or number of marijuana items transferred for free to eligible patients or designated primary caregivers in accordance with this rule; and

(d) The amount or number of marijuana items by type transferred at a discounted price to eligible patients or designated primary caregivers in accordance with this rule, broken down by the amount discounted.

(5) The report submitted by a dispensary under section (4) of this rule may not contain any individually identifiable information.

(6) Nothing in this rule prohibits a dispensary from providing free or discounted marijuana items to any patient or designated primary caregiver.

Stat. Auth.: OL 2016, ch. 23, sec. 22

Stats. Implemented: OL 2016, ch. 23, sec. 22

Hist.: PH 33-2016, f. & cert. ef. 11-28-16

333-008-1500

Medical Marijuana Dispensaries: Limited Marijuana Retail Sales

(1) For purposes of OAR 333-008-1500 through 333-008-1505 the following definitions apply:

(a) "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; 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.

(b) "Cannabinoid edible" means:

(A) A food or potable liquid into which a cannabinoid concentrate, cannabinoid extract or dried marijuana leaves or flowers have been incorporated.

(B) "Cannabinoid edible" does not include a tincture or a cannabinoid product intended to be placed under the tongue or in the mouth using a dropper or spray delivery method, such as but not limited, to a sublingual spray.

(c) "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.

(d)(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, which contains cannabinoids or dried marijuana leaves or flowers.

(B) "Cannabinoid product" does not include:

(i) Usable marijuana by itself;

(ii) A cannabinoid concentrate by itself;

(iii) A cannabinoid extract by itself; or

(iv) Industrial hemp, as defined in ORS 571.300.

(e) "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.

(f) "Cannabinoid topical" means a cannabinoid product intended to be applied to skin or hair.

(g) "Dried leaves and flowers of marijuana" means the cured and dried leaves and flowers from a mature marijuana plant that have not been chemically altered or had anything added to them.

(h) "Immature marijuana plant" means a marijuana plant that is not flowering.

(i) "Individual" means a person 21 years of age or older who is not a patient or designated primary caregiver.

(j) "Limited marijuana retail product" means:

(A) The seeds of marijuana;

(B) The dried leaves and flowers of marijuana;

(C) An immature marijuana plant;

(D) Cannabinoid edibles;

(E) Nonpsychoactive medical cannabinoid products intended to be applied to a person's skin or hair; and

(F) Prefilled receptacles of cannabinoid extracts.

(k) "Low-dose cannabinoid edible" means a cannabinoid edible that has no more than 15 milligrams of THC in a unit.

(l) "Marijuana" means the plant Cannabis family Cannabaceae, any part of the plant Cannabis family Cannabaceae and the seeds of the plant Cannabis family Cannabaceae.

(m) "Medical cannabinoid product" has the meaning given that term in ORS 475B.410.

(n) "Medical marijuana dispensary" or "dispensary" means an entity registered with the Oregon Health Authority under ORS 475B.450.

(o) "Nonpsychoactive medical cannabinoid product intended to be applied to a person's skin or hair":

(A) Means a cannabinoid topical with a THC content of not more than six percent that does not affect the mind or mental processes.

(B) Does not mean a transdermal patch.

(p) "Photographic identification" means valid government issued identification with a photograph of the individual that includes the individual's last name, first name, and date of birth.

(q) "Prefilled receptacle of cannabinoid extract" means a single use receptacle prefilled with a cannabinoid extract by itself.

(r) "Unit" means a package for sale.

(2) Until January 1, 2017, a medical marijuana dispensary may sell limited marijuana retail product to an individual in accordance with this rule if:

(a) The dispensary, five days prior to selling any limited marijuana retail product notifies the Authority, on a form prescribed by the Authority, that the dispensary intends to sell limited marijuana retail product;

(b) The city or county in which the dispensary operates has not adopted an ordinance prohibiting the sale of limited marijuana retail product; and

(c) The Authority has not prohibited the dispensary from selling limited marijuana retail product under section (14) of this rule.

(3) A dispensary that is permitted to sell limited marijuana retail product:

(a) Must examine the photo identification of all individuals before entering the dispensary to ensure the individual is 21 years of age or older.

(b) Must verify at the time of sale that the individual is 21 years of age or older by examining the individual's photographic identification.

(c) May only sell limited marijuana retail product as specified in sections (4) to (6) of this rule.

(4) A dispensary may sell one-quarter ounce of dried leaves and flowers to an individual per day.

(5) Between June 2 and December 31, 2016 a dispensary may sell:

(a) One unit of a single-serving, low-dose cannabinoid edible to an individual per day. A unit of a low-dose cannabinoid edible can contain more than one edible as long as the total THC in the unit does not exceed 15 milligrams.

(b) One prefilled receptacle of a cannabinoid extract that does not contain more than 1,000 milligrams of THC to an individual per day.

(c) Nonpsychoactive medical cannabinoid products intended to be applied to a person's skin or hair.

(6) A dispensary may sell up to four immature marijuana plants to the same individual at any time between October 1, 2015 and December 31, 2016.

(7) A dispensary may not:

(a) Offer, sell or provide a cannabinoid product, extract or concentrate to an individual except as provided in sections (4) through (6) of this rule; or

(b) Give away a limited marijuana retail product to an individual.

(8) For each limited marijuana retail product sale, a dispensary must document:

(a) The limited marijuana retail product that was sold and the amount in metric units or number sold as applicable;

(b) The birth date of the individual who bought the product;

(c) The sale price; and

(d) The date of sale.

(9) A dispensary may sell non-marijuana items to an individual, such as but not limited to branded clothing.

(10) A dispensary is not required to maintain a record of the name of the individual to whom a limited marijuana retail product was sold but the dispensary must have a system in place that is outlined in its policies and procedures for ensuring that an individual is not sold more than the amount or number of a limited retail marijuana product permitted under this rule.

(11) Records of sale transactions and the documentation required in section (8) of this rule shall be maintained in accordance with the Authority's record keeping requirements for dispensaries.

(12) A dispensary that chooses to sell limited marijuana retail product to individuals must:

(a) Post at the point the sale, the following posters prescribed by the Authority, measuring 22 inches high by 17 inches wide that can be downloaded at www.healthoregon.org/marijuana:

(A) A Pregnancy Warning Poster; and

(B) A Poisoning Prevention Poster.

(b) Post at the point of sale 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.

(c) Distribute to each individual at the time of sale, a Marijuana Information Card, prescribed by the Authority, measuring 3.5 inches high by 5 inches long that can be downloaded at www.healthoregon.org/marijuana.

(d) Comply with all rules in OAR chapter 333, divisions 7 and 8 that apply to dispensaries including but not limited to all security, testing, labeling, except as provided in section (13) of this rule, packaging and documentation rules except rules that:

(A) Prohibit individuals from entering or being present in a dispensary; and

(B) Prohibit a dispensary from transferring marijuana to an individual.

(e) On and after January 4, 2016:

(A) Collect a tax of 25 percent of the retail sales price of a limited marijuana retail product in the same manner that a marijuana retailer that holds a license under section 22, chapter 1, Oregon Laws 2015, collects the tax imposed under section 2, chapter 699, Oregon Laws 2015;

(B) Comply with all requirements in sections 1 through 13, chapter 699, Oregon Laws 2015, and any applicable administrative rules adopted by the Department of Revenue; and

(C) If requested by the Authority, sign an authorization to permit the sharing of information between the Authority and the Department of Revenue concerning tax collection required by section 21a, chapter 699, Oregon Laws 2015.

(13) A dispensary:

(a) May substitute a warning that reads "For use by adults 21 and older. Keep out of reach of children" for the warning "For use by OMMP patients only. Keep out of reach of children" on labels for limited marijuana retail products.

(b) Must:

(A) Comply with the packaging requirements in OAR 845-025-7000 to 845-025-7060 for all limited marijuana retail products.

(B) Comply with any labeling requirements in OAR 333-007-0010 to 333-007-0100 for limited marijuana retail products that would be applicable to a similar item sold by an Oregon Liquor Control Commission licensee.

(14) The Authority may, if it determines that a dispensary has violated OAR 333-008-1500 through 333-008-1505:

(a) Prohibit a dispensary from selling limited marijuana retail product; and

(b) Take any action authorized under OAR 333-008-2190.

(15) A dispensary may not sell limited marijuana retail product to individuals if the dispensary is located in a city or county that has adopted an ordinance prohibiting such sales in accordance with section 3, chapter 784, Oregon Laws 2015.

(16) A dispensary that has had its registration suspended may not sell limited marijuana retail product while the registration is suspended.

(17) This rule is only in effect until January 1, 2017.

Stat. Auth.: ORS 475.314 & 475.338, OL 2015, ch. 784 & sec. 21a, ch. 699, OL 2015
Stats. Implemented: ORS 475.314, OL 2015, ch. 784 & sec. 21a, ch. 699, OL 2015
Hist.: PH 16-2015(Temp), f. & cert. ef. 9-22-15 thru 3-19-16; PH 8-2016, f. 2-26-16, cert. ef. 3-1-16; PH 16-2016(Temp), f. 5-20-16, cert. ef. 6-2-16 thru 11-28-16; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1505
Medical Marijuana Dispensaries: Reporting Requirements

(1) A dispensary that is selling limited marijuana retail products to individuals must by April 10, 2016, July 10, 2016, October 10, 2016, and January 10, 2017, report to the Authority, in a manner prescribed by the Authority, the information required to be documented in OAR 333-008-1500(4) for the previous quarter.

(2) A dispensary must submit, by April 10, 2016, the information required to be documented in OAR 333-008-1500(4) for October 1, 2015 through December 31, 2015.

(3) A dispensary selling limited marijuana retail products to individuals must provide proof to the Authority by May 10, 2016, August 10, 2016, November 10, 2016, and February 10, 2017, in a manner prescribed by the Authority, that it has paid the tax required by the Department of Revenue for the previous quarter. Documentation may include but is not limited a

copy of the marijuana tax returns, reports, payment vouchers, payment receipts or any related documents filed with the Department.

Stat. Auth.: ORS 475B.450 & 475B.525, OL 2015, ch. 784
Stats. Implemented: ORS 475B.450, OL 2015, ch. 784
Hist.: PH 8-2016, f. 2-26-16, cert. ef. 3-1-16; PH 16-2016(Temp), f. 5-20-16, cert. ef. 6-2-16 thru 11-28-16; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1620
Medical Marijuana Processors: Application for Medical Marijuana Processing Site Registration

(1) This rule applies to any initial application filed on or after June 28, 2016 and to any initial application filed prior to June 28, 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 required under section (3) of this rule 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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1730
Medical Marijuana Processors: 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. 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 the limited access area and an area that is open to the general public except through a door that is kept locked by a processing site when the door is not immediately in use.

(9) The areas described in section (8) of this rule must be clearly marked on the scaled floor plan required in OAR 333-008-1620.

(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:

(a) As permitted in OAR 333-008-1790; or

(b) A registered dispensary under common ownership.

(12) If a processing site premises is located in a building or structure that includes residential, industrial, agricultural or other commercial uses, occupancies or tenant space, the processing site premises and any other use, occupancy or tenant space must be completely separate with no communication of space or means of ingress or egress between the processing site premises and any other use, occupancy or tenant space, except as follows:

(a) A processing site may share a premises with a registered marijuana dispensary that is under common ownership, in accordance with section (13) of this rule and OAR 333-008-2080.

(b) A processing site is permitted to have a door from the processing site premises that opens into a common space shared by other commercial uses, occupants, tenants or the public, but that is not exclusively under the control or possession of a single other commercial use, occupancy or tenancy, in accordance with section (13) of this rule.

(13) If a processing site premises is located in a building or structure that includes residential, industrial, agricultural or other commercial uses, occupancies or tenant space and under section (12) of this rule ingress or egress is permitted, every means of ingress and egress must be:

(a) Through a door that is locked at all times, when not in immediate use, by a commercial grade lock, and that does not permit access by the public.

(b) Posted with signage in accordance with OAR 333-008-1730, as applicable.

(c) Equipped with security and surveillance system coverage in accordance with OAR 333-008-2080 and 333-008-2100.

(14) Residential occupancy of a processing site premises is prohibited.

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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1740

Medical Marijuana Processors: 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. On and after October 1, 2016, a registered processing site must comply with the applicable sampling and testing requirements in 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 or that has failed a test under OAR 333-007-0450 and the product, concentrate or extract cannot be remediated.

(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 or that has failed a test under OAR 333-007-0450 and the product, concentrate or extract cannot be remediated.

(10) Packaging and Labeling. 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; PH 27-2016(Temp), f. & cert. ef. 9-30-16 thru 3-1-17; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1760

Medical Marijuana Processors: 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, on a form prescribed by the Authority, 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;

(E) The harvest or process lot numbers; and

(F) The amount 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) Nothing in these rules requires a registered processing site to accept a transfer of a marijuana item.

(7) 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, 475B.443
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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1770
Medical Marijuana Processors: 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, on a form prescribed by the Authority:

(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 process lot numbers associated with the transfer;

(e) The date of the transfer; and

(f) 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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-1820
Medical Marijuana Processors: Registered Processing Site Recordkeeping

(1) In addition to other record keeping required in these rules a registered processing site must keep records documenting the following:

(a) How much marijuana is in each process lot, as that term is defined in OAR 333-007-0020.

(b) For usable marijuana used in a process lot, the harvest lot number associated with that usable marijuana.

(c) For cannabinoid concentrates, extracts or products used in a process lot, the process lot number associated with that concentrate, extract or product.

(d) If a product is returned by a registered dispensary, how much product is returned and why.

(e) If a defective product was reprocessed, how the defective product was reprocessed.

(f) Each training provided in accordance with OAR 333-008-1750, the names of employees who participated in the training, and a summary of the information provided in the training.

(g) All testing results.

(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 Authority requires a processor to submit or produce documents to the Authority 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.435, 475B.440
Stats. Implemented: ORS 475B.435, 475B.440
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 33-2016, f. & cert. ef. 11-28-16

333-008-2080
General Requirements for Medical Marijuana Processing Sites and Dispensaries: 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, except that a registered processing site may keep all usable marijuana, cut and drying mature marijuana plants, cannabinoid concentrates, extracts or products on the premises in a secure area.

(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.

(8) Notwithstanding OAR 333-008-2090 to 333-008-2120 a registered processing site and registered dispensary under common ownership that share a premises are not required to install redundant security systems if the premises are directly accessible to each other by an adjoining door. If a shared security system is utilized:

(a) Any point of common ingress and egress between the premises shall be treated as an external door, for purposes of this rule, and must have security coverage in accordance with sections (1) and (3) of this rule; and

(b) The registrants must maintain the system and provide access to the Authority in accordance with these rules.

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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-2120
General Requirements for Medical Marijuana Processing Sites and Dispensaries Location and Maintenance of Surveillance Equipment

(1) A registrant must:

(a) Have the surveillance recording equipment housed in a designated secure area or other locked enclosure with access limited to:

(A) The registrant and authorized personnel of the registrant;

(B) Employees of the Authority;

(C) State or local law enforcement agencies for any other state or local law enforcement purpose; and

(D) Service personnel or contractors.

(b) Keep a current list of all authorized personnel and service personnel who have access to the surveillance system and room on the registered premises.

(c) Keep a surveillance equipment maintenance activity log on the registered 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.

(2) A registrant may store video recordings offsite as long as a PRD or PRP can demonstrate that the recordings are secure and protected, that the recordings are kept for a minimum of 45 calendar days as required in OAR 333-008-2110 and that the Authority can access the video recordings upon request.

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 33-2016, f. & cert. ef. 11-28-16

333-008-2190
General Requirements for Medical Marijuana Processing Sites and Dispensaries 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) 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.

(d) If the written plan of correction is acceptable, the Authority must notify the registrant in writing and specify a date by which the registrant must come into compliance.

(e) If the registrant does not come into compliance by the date specified by the Authority 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; PH 33-2016, f. & cert. ef. 11-28-16

333-008-9900
Waiver of Replacement Card Fee

Notwithstanding OAR 333-008-0021(5) or 333-008-0047(1)(b), until January 1, 2017, the Authority will not impose or collect a $100 replacement card fee if the reason for the replacement card is that the patient is designating a new PRMG or new grow site address.

Stat. Auth.: ORS 475B.415, 475B.420, 475B.525
Stats. Implemented: ORS 475B.415
Hist.: PH 13-2016(Temp), f. 4-13-16, cert. ef. 4-15-16 thru 9-30-16; PH 33-2016, f. & cert. ef. 11-28-16

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Rule Caption: Manufacturer Disclosure of High Priority Chemicals of Concern for Children's Health Used in Children's Products
Adm. Order No.: PH 34-2016
Filed with Sec. of State: 12-1-2016
Certified to be Effective: 12-1-16
Notice Publication Date: 10-1-2016
Rules Adopted: 333-016-2035, 333-016-2040, 333-016-2050, 333-016-2060, 333-016-2070, 333-016-2090
Subject: The Oregon Health Authority (Authority), Public Health Division is permanently adopting administrative rules in chapter 333, division 16 related to high priority chemicals of concern for children's health.

SB 478 (Oregon Laws 2015, chapter 786) was passed by the Oregon Legislature during the 2015 legislative session. The law requires the Authority to develop rules to implement the Toxic Free Kids Program. These rules require manufacturers of children's products to disclose high priority chemicals of concern for children's health used in children's products that are sold or offered for sale in Oregon. These rules also establish requirements for disclosure; a process for manufacturers to apply for an exemption from the disclosure requirements; and describe the Authority's civil penalty authority and enforcement process should a manufacturer not comply with the requirements of the rules.
Rules Coordinator: Brittany Hall—(971) 673-1291

333-016-2035
Manufacturer Disclosure of High Priority Chemicals of Concern for Children's Health Used in Children's Products: Practical Quantification Limits

(1) The practical quantification limit for a chemical that is a contaminant is 100 parts per million.

(2) The practical quantification limits for intentionally added chemicals are the limits established in Exhibit A, incorporated by reference. [Exhibit not included. See ED. NOTE.]

[ED. NOTE: Exhibit Referenced is not included in rule text]

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 431A.253–431A.280
Hist.: PH 34-2016, f. & cert. ef. 12-1-16

333-016-2040
Purpose and Scope

OAR 333-016-2035 through 333-016-2090:

(1) Require manufacturers of children's products to disclose high priority chemicals of concern for children's health used in children's products, unless the manufacturer is exempt;

(2) Establish requirements for disclosure;

(3) Establish a process for a manufacturer to apply for an exemption from the disclosure requirements; and

(4) Describe the Authority's civil penalty authority and enforcement process.

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 431A.253–431A.280
Hist.: PH 34-2016, f. & cert. ef. 12-1-16

333-016-2050
Definitions

(1) "Authority" means the Oregon Health Authority.

(2) "Chemical" has the meaning given that term in ORS 431A.253.

(3) "Chemical Abstracts Service Registry Number" means the number assigned for identification of a particular chemical by the Chemical Abstracts Service, a service of the American Chemical Society that indexes and compiles abstracts of worldwide chemical literature called Chemical Abstracts.

(4) "Child" means an individual under 12 years of age.

(5) "Children's product" has the meaning given that term in ORS 431A.253.

(6) "Component part" means a uniquely identifiable material or coating (including ink or dye) that is intended to be included as a part of a finished children's product, including, but not limited to:

(a) Bio-based Materials (Animal or Plant based);

(b) Synthetic Polymers (such as but not limited to synthetic rubber, plastics, and foams);

(c) Metals (including alloys);

(d) Glass, Ceramic and Siliceous material;

(e) Surface coatings (such as but not limited to paints, plating, and waterproofing);

(f) Homogenous Mixtures (gels, creams, powders, liquids, adhesives, synthetic fragrances);

(g) Inks/Dyes/Pigments; and

(h) Textiles (synthetic fibers and blends).

(7) "Contaminant" has the meaning given that term in ORS 431A.253.

(8) "De minimis level" has the meaning given that term in ORS 431A.253.

(9) "HPCCCH" means high priority chemicals of concern to children's health.

(10) "High priority chemicals of concern list" means the high priority chemicals of concern for children's health identified by the Authority in OAR 333-016-2020.

(11) "Intentionally added chemical" has the meaning given that term in ORS 431A.253.

(12) "Manufacturer" has the meaning given that term in ORS 431A.253

(13) "Manufacturing control program" means a program implemented by the manufacturer or its suppliers to control the amount of a high priority chemical of concern in children's products present as a contaminant at or above de minimis through the implementation of tools, processes and oversight that support effective chemicals management at all levels to include supply chain management, quality assurance and educational programs. Control includes the minimization, reduction or elimination of contaminants when possible.

(14) "Mouthable" has the meaning given that term in ORS 431A.253.

(15) "Owner" for purposes of clarifying the definition of "manufacturer" means the first person or entity, whether an importer or a distributor, that first offers the children's product for sale in Oregon.

(16) "Practical quantification limit" has the meaning given that term in ORS 431A.253.

(17) "Product category" means the "brick" level of the GS1 Global Product Classification (GPC) standard, which identifies products that serve a common purpose, are of a similar form and material, and share the same set of category attributes.

(18) "These rules" means OAR 333-016-2040 to 333-016-2100.

(19) "Trade association" has the meaning given that term in ORS 431A.253.

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 431A.253–431A.280
Hist.: PH 34-2016, f. & cert. ef. 12-1-16

333-016-2060
Notification Requirements

(1) No later than January 1, 2018, and every other year thereafter, a manufacturer of a children's product sold or offered for sale in this state that contains a HPCCCH listed in OAR 333-016-2020 in an amount at or above a de minimis level must submit a notice to the Authority that contains all the information required in these rules, unless the manufacturer or product is exempt.

(2) The first manufacturer's notice due on January 1, 2018, applies to children's products sold or offered for sale in this state between January 1, 2017 and December 31, 2017.

(3) Future notices apply to children's products sold or offered for sale during the previous two year period. For example, for the reporting year 2020, a manufacturer must include children's products sold or offered for sale between January 1, 2018, and December 31, 2019, that contain a HPCCCH listed in OAR 333-016-2020.

(4) The notice required in section (1) of this rule must include the following:

(a) The name and Chemical Abstracts Service Registry Number of the chemical contained in the children's product;

(b) The product category of the children's product that contains the chemical;

(c) A description of the function of the chemical in the children's product;

(d) The amount of the chemical used in each unit of the children's product reported as a range rather than an exact amount;

(e) The name and address of the manufacturer, and the name, address and telephone number of the contact person for the manufacturer; or

(f) The name, address and contact information for the trade association submitting the notification on behalf of the affected industry; and

(g) Any other information that the manufacturer deems relevant to the appropriate use of the children's product.

(5) The second biennial notice will cover the period of January 1, 2018 through December 31, 2020.

(6) If a manufacturer has included a children's product in a notice required under these rules, and determines that there is no change to the information submitted to the Authority in the previous notice, the manufacturer may, in lieu of including the children's product again in a subsequent notice, submit a written statement, or if available, an electronic notification indicating that the previous reported data is still valid for that children's product.

(7) A trade association may provide the notice required in these rules on behalf of a member manufacturer.

(8) A trade association who fulfills the notice or exemption requirements of these rules on behalf of a member manufacturer will not be held liable for a violation or penalty as a result of the member manufacturer's noncompliance with the requirements of these rules.

(9) A manufacturer may, during the notification process, submit to the Authority recommendations regarding technical, financial or logistical support considered necessary for the implementation of innovation and green chemistry solutions related to HPCCCH used in children's products.

Stat. Auth: ORS 413.042, 431A.258
Stats. Implemented: ORS 431A.258
Hist.: PH 34-2016, f. & cert. ef. 12-1-16

333-016-2070
Exemptions from Notice Requirement

(1) A manufacturer of children's products with annual worldwide gross sales of less than $5 million, as reported on the most recent tax return filed by the manufacturer before the notification required under OAR 333-016-2060, is exempt from all the requirements of these rules.

(2) If, following the filing of the most recent tax return, a manufacturer's annual worldwide gross sales are $5 million or more, the manufacturer must submit a notice as required under OAR 333-016-2060. The notice must be submitted during the next applicable reporting period or within 180 days of the filing, whichever is later.

(3) A manufacturer or trade association may submit to the Authority a request for an exemption from these rules if the HPCCCH in a children's product is present only as a contaminant at or above the de minimis level, and a manufacturing control program is in place.

(4) In order to meet the standards for an exemption a manufacturing control program must be structured using at least one of the following categories:

(a) Manufacturing processes, for example polymerization of plastic resin, injection-molding of plastic, pad-transfer printing, silk screening;

(b) Materials or group of materials, for example multiple styrenic plastics;

(c) Component parts;

(d) A HPCCCH present as a contaminant at or above the de minimis level; or

(e) Finished products.

(5) In addition to the information provided in section (4) of this rule a manufacturer must document in its exemption request the specific HPCCCH present as a contaminant at or above the de minimis level that the manufacturing control program is intended to address and the product categories where the HPCCCH are found.

(6) In order for the manufacturer to demonstrate that a manufacturing control program meets the minimum standards for an exemption, the manufacturing control program must meet generally-recognized industry best manufacturing practices and processes for the control of a HPCCCH, such as but not limited to:

(a) The most current and appropriate International Standards Organization (ISO) requirements for a specific manufacturing process or facility. The manufacturer must demonstrate how the ISO certification held by the manufacturer or supplier is controlling the contaminant in a component part or in the finished children's product;

(b) Another established certification or standards manufacturing control program such as, but not limited to, Sony Corporations Green Partners Standards, the European ROHS (Restriction of Hazardous Substances in Electronic Parts), EN 79.

(c) The most current American Society for Testing and Materials (ASTM) International standards that provide the recommended industry standards for materials used or produced in the manufacturing process;

(d) Any proven alternative methodology that will enable the manufacturer to demonstrate:

(A) That the methodology controls the contaminant to the lowest practicable levels in the finished children's product; and

(B) That the alternative methodology is as or more effective at controlling the contaminant than the standards in subsections (a) through (c) of this section.

(7) In addition to meeting one of the requirements of subsections (6)(a) through (d) of this rule a manufacture must document and describe, in its exemption request, whether the manufacturer's or the manufacturer's supplier's manufacturing control process, include any of the following:

(a) Procedures to ensure the quality and purity of feedstock, whether raw or recycled;

(b) Contract specifications for manufacturing process parameters, for example material purity, drying and curing times when relevant to the presence of high priority chemicals in the finished children's product components;

(c) Periodic testing for the presence and amount of HPCCCH in the finished children's product, including documentation of how tests were conducted and applicable lab results from an accredited third party laboratory;

(d) Procedures and approaches to audit the methods used by contractors or suppliers to control a HPCCCP present as a contaminant in a children's product; and

(e) Education and outreach to members of a supply chain about the importance to the manufacturer of controlling the amount of HPCCCH in supplied materials through activities such as discussions with suppliers, oral presentations, written materials or webinars.

(8) The Authority, upon receipt of an exemption request will date stamp the document. Once date stamped the Authority must approve or deny an exemption request within 180 days.

(a) If the Authority does not approve or disapprove the exemption request within 180 days the manufacturing control program exemption is deemed approved.

(b) If the Authority approves the exemption the Authority will notify the manufacturer of the approval, in writing.

(c) If an exemption request is disapproved, the Authority will provide written notice to the manufacturer of the disapproval and the reason for the disapproval.

(9) If the Authority disapproves an exemption request, the manufacturer may submit a revised exemption request for consideration within 180 days after the Authority's notice of disapproval.

(10) If the exemption request is denied a second time, the manufacturer will have 90 days from the date of the written notification of disapproval to submit a notification in accordance with OAR 333-016-2060.

(11) At any time the Authority may request additional information from a manufacturer requesting an exemption.

(12) If a manufacturer submits information to the Authority as part of its request for an exemption under this rule that the manufacturer believes is a trade secret, the manufacturer must mark the information "confidential — trade secret."

(a) If the Authority receives a public records request for records related to a request for an exemption under this rule, it will review all documents submitted by the manufacturer to determine whether the documents contain trade secrets that would be exempt from disclosure under Oregon's Public Records Act, ORS 192.501(2).

(b) For purposes of this section "trade secret" has the meaning given that term in ORS 192.501(2).

Stat. Auth: ORS 413.042, 431A.258, 431A.268
Stats. Implemented: 431A.258, 431A.268
Hist.: PH 34-2016, f. & cert. ef. 12-1-16

333-016-2090
Enforcement and Civil Penalties

(1) The Authority may impose a civil penalty on a manufacturer for a violation of any provision of ORS 431A.258 or these rules. A civil penalty may not exceed:

(a) $2,500 for the first violation.

(b) $5,000 for the second and each subsequent violation.

(2) For purposes of assessing civil penalties under these rules a violation consists of a single course of conduct with regard to an entire children's product line that is sold or offered for sale in this state.

(3) If a manufacturer violates the notification requirement described in ORS 431A.258 the Authority shall provide the manufacturer with written notice informing the manufacturer of the violation and stating that the manufacturer may avoid a civil penalty for the violation by providing the proper notice required under ORS 431A.258 within 90 days.

(a) If the manufacturer fails to cure the violation within the first 90 days, the Authority may impose a civil penalty not to exceed $2,500. For a continuing violation, each 90-day period that the violation continues after the preceding imposition of a civil penalty is considered a separate offense subject to a separate civil penalty not to exceed $5,000. The Authority is not required to provide the manufacturer with an opportunity to cure the continuing violation before imposing the separate civil penalty.

(4) If the Authority has reason to believe that a children's product that contains a HPCCCH used in children's products is being sold or offered for sale in this state in violation of ORS 431A.258 the Authority may request that the manufacturer provide a statement of compliance on a form provided by the Authority. The manufacturer must submit the statement of compliance within 10 days after receipt of a request. To prove compliance with ORS 431A.258 the manufacturer must provide:

(a) Evidence that the children's product does not contain the HPCCCH used in children's products;

(b) Evidence that the manufacturer has previously provided the Authority with notice as required by ORS 431A.258 and these rules; or

(c) Provide the Authority with notice as required by ORS 431A.258 and OAR 333-016-2060.

(5) In imposing a penalty under these rules the Authority must consider the following factors:

(a) The past history of the manufacturer in taking all feasible steps or following all feasible procedures necessary or appropriate to correct any violation.

(b) Any prior violations of statutes, rules, orders or permits pertaining to HPCCCH used in children's products.

(c) The gravity and magnitude of the violation.

(d) Whether the violation was a sole event, repeated or continuous.

(e) Whether the violation was a result of an unavoidable accident, negligence or an intentional act.

(f) The violator's cooperativeness and efforts to correct the violation.

(g) The economic and financial conditions of the manufacturer incurring a penalty.

(h) The manufacturer's declaration that a HPCCCH used in a children's product is present only as a contaminant, and the manufacturer is able to provide evidence that a manufacturing control program for the contaminant that meets or exceeds the minimum requirements for a manufacturing control program in OAR 333-016-2070 was in place prior to the violation and that the manufacturer has exercised due diligence.

(6) Civil penalties will be imposed in the manner provided in ORS 183.745.

Stat. Auth: ORS 431A.275
Stats. Implemented: ORS 431A.275
Hist.: PH 34-2016, f. & cert. ef. 12-1-16

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Rule Caption: Cannabis Testing
Adm. Order No.: PH 35-2016(Temp)
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Certified to be Effective: 12-2-16 thru 5-30-17
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Rules Amended: 333-007-0310, 333-007-0315, 333-007-0320, 333-007-0350, 333-007-0360, 333-007-0410, 333-007-0430, 333-007-0440, 333-007-0450, 333-007-0480, 333-064-0100, 333-064-0110, 333-007-0090
Rules Suspended: 333-007-0490
Subject: The Oregon Health Authority, Public Health Division, Oregon Medical Marijuana Program is temporarily amending and suspending administrative rules in chapter 333, divisions 7 and 64 pertaining to testing.

The Oregon Health Authority establishes rules and standards for the testing of marijuana items. As of October 1, 2016, all marijuana items must be tested to standards outlined in division 7 and division 64 of the testing rules. These temporary rules reduce the regulatory burden and costs of testing marijuana for registered and licensed marijuana growers, producers and processors. The temporary rules will likely reduce regulatory costs that will in effect increase market access of marijuana items to consumers and medical marijuana patients while still ensuring the implementation of statutorily required testing standards. In addition, these rules amend and clarify requirements for registrants and licensees regarding follow up of failed test results, and amend and clarify test result reporting requirements for laboratories so that the Authority can ensure that marijuana and marijuana items are safe for consumers and medical marijuana patients. The temporary rules reduce the number of solvent analytes that must be tested for, clarify the minimum number of sample increments that must be taken for testing for cannabinoid concentrates, extracts and products, and update the sampling protocols to be consistent with the rule changes.
Rules Coordinator: Brittany Hall—(971) 673-1291

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, plus or minus five percent.

(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; PH 33-2016, f. & cert. ef. 11-28-16; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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) "Control study" means a study performed on products or matrices of unknown homogeneity to assure required uniformity of product accomplished through sampling and testing as described in OAR 333-007-0440.

(19) "Delta-9 THC" is the principal psychoactive constituent (the principal cannabinoid) of cannabis, Chemical Abstracts Service Number 1972-08-3.

(20)(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.

(21) "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.

(22) "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.

(23) "Grower" has the same meaning as "person responsible for a marijuana grow site."

(24) "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.

(25) "Harvest lot" means a specifically identified quantity of marijuana that is cultivated utilizing the same growing practices, harvested within a 48-hour period at the same location and cured under uniform conditions.

(26) "Homogeneous" means a cannabinoid product, concentrate or extract has uniform composition and properties throughout each process lot.

(27) "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.

(28) "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.

(29) "Licensee" has the meaning given that term in ORS 475B.015.

(30)(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 item" means marijuana, usable marijuana, a cannabinoid product or a cannabinoid concentrate or extract.

(32) "Marijuana processing site" means a marijuana processing site registered under ORS 475B.435.

(33) "Medical marijuana dispensary" or "dispensary" means a medical marijuana dispensary registered under ORS 475B.450.

(34) "ORELAP" means the Oregon Environmental Laboratory Accreditation Program administered by the Authority pursuant to ORS 438.605 to 438.620.

(35) "Patient" has the same meaning as "registry identification cardholder."

(36) "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.

(37) "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.

(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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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 a successful control study, 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

333-007-0320
Testing Requirements for Marijuana or Usable Marijuana

(1) A producer or grower must test every batch from a 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 batch from a 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 every batch from a 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.

(4) A producer or grower must test a batch from 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.

(5) 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

333-007-0350
Batch Requirements

(1) Usable marijuana. A producer or grower must separate each harvest lot into no larger than 10 pound batches.

(2) Cannabinoid concentrates and extracts and cannabinoid products, except cannabinoid edibles. (a) A process lot is considered a batch.

(b) The size of a process lot submitted for sampling and testing for purposes of a control study under OAR 333-007-0440 defines the maximum process lot for that concentrate, extract or product for purposes of sampling and testing after a control study has been certified.

(3) Cannabinoid edibles. A processor or processing site must separate process lots into not larger than 1000 unit batches.

(4) 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.

(5) 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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).

(c) A portion of samples taken from multiple batches of usable marijuana may be combined for purposes of testing for THC and CBD if the batches are the same strain.

(d) A portion of samples taken from multiple batches of usable marijuana may be combined for purposes of testing for pesticides if the multiple batches in total do not exceed 10 pounds. If the combined samples fail for pesticides all the batches fail.

(2) Cannabinoid concentrates, extracts and products.

(a) At a minimum, samples must be taken in increments established in Exhibit B, incorporated by reference. Enough samples from a batch must be taken to ensure that the required attributes in the batch to be tested are homogenous and must be taken in a manner 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 a control study, future batches of that concentrate, extract or product with a valid certification, as described in OAR 333-007-0440, may have sample increments combined into a field primary and field duplicate sample in accordance with OAR 333-007-0440 and 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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 a control study 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 by over 5 percent 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 a control study 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 by over 5 percent 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

333-007-0440
Control Study

(1) A laboratory may perform a control study on a process lot 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 a control study; and

(b) For cannabinoid products, the expected THC range for the product.

(2) Samples taken for purposes of a control study 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 a control study 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 by more than 5 percent 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 a control study has passed for any of the following, and must send the form at the client's request to the Authority or the Commission:

(a) Pesticides, if applicable.

(b) Solvents, if applicable.

(c) THC concentration as calculated pursuant to OAR 333-064-0100, if applicable.

(7) A control study fails if:

(a) Any sample exceeds an action limit in OAR 333-007-0400 or 333-007-0410. A sample that exceeds an action limit may not be reanalyzed and retested under OAR 333-007-0450(1) unless the laboratory determines that the result is due to laboratory error.

(b) The amount of THC, as calculated pursuant to OAR 333-064-0100, between samples taken from the batch exceeds 30 percent RSD.

(c) The amount or percentage of THC as calculated pursuant to OAR 333-064-0100, exceeds the maximum concentration limit permitted in a package by more than 5 percent as specified in OAR 333-007-0200 to 333-007-0220, as applicable.

(8) A process lot sampled and tested for purposes of a control study may be sold or transferred if the samples pass all the required tests.

(9) If a cannabinoid concentrate, extract or product successfully passes a control study the following apply to sampling of future batches for one year:

(a) Sample increments may be collected and combined into a primary sample as described in OAR 333-064-0100, ORELAP-SOP-002 Rev. 3.0.

(b) A field duplicate sample must be collected along with the primary sample as described in OAR 333-064-0100, ORELAP-SOP-002 Rev. 3.0.

(c) The minimum number of sample increments are described in OAR 333-007-0360(2)(a).

(10) The certification of a control study is invalidated if a processor or processing site makes any changes:

(a) To the standard operating procedures for that product.

(b) In the type of ingredient in the product.

(11) For purposes of section (10) of this rule it is not considered a change to standard operating procedures or a change in the type of ingredient if the processor or processing site is using:

(a) Different strains of usable marijuana in batches.

(b) An ingredient with a different level of purity as long as the purity of the ingredient complies with the Authority's or the Commission's processing rules.

(c) Different flavors or colors in batches, as long as the different flavors or colors do not have an effect on the potency of the product.

(12) The Authority will certify a control study for registrants. The Commission will certify a control study for licensees.

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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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.

(a) If a registrant or licensee wishes to have a sample reanalyzed, the registrant or licensee must request a reanalysis within seven calendar days from the date the laboratory sent notice of the failed test to the registrant or licensee. The reanalysis must be completed by the laboratory within 30 days from the date the reanalysis was requested.

(b) If a registrant or licensee has requested a reanalysis in accordance with subsection (1)(a) of this rule and the sample passes, the registrant or licensee has seven calendar days from the date the laboratory sent notice of the passed test to request that another laboratory resample the batch and confirm the passed test result. The retesting must be completed by the second laboratory within 30 days from the date the retesting was requested.

(c) A registrant or licensee must inform the Authority or the Commission immediately, of the following, in a manner prescribed by the Authority or the Commission:

(A) A request for reanalysis of a sample;

(B) The testing results of the reanalysis;

(C) A request for retesting; and

(D) The results of retesting.

(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 as ordered by the Authority or the Commission. A batch may not be destroyed without obtaining permission from 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, in accordance with OAR 333-008-0650.

(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) 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.

(11) 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.

(12) If a batch fails a test under these rules a registrant:

(a) Must store and segregate the batch in a secure area and label the batch clearly to indicate it has failed a test and the label must include a test batch number.

(b) May not remove the batch from the registered premises without permission from the Authority.

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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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.

(4) Any testing ordered under this rule must be paid for by the registrant.

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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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; Suspended by PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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 3.0; and

(B) Concentrates, Extracts, and Products: ORELAP-SOP-002 Rev 3.0.[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 a control study or has not yet gone through a control study.

(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:

$M_{\text{total delta-9 THC}} = M_{\text{delta-9 THC}} + 0.877 \times M_{\text{delta-9 THCA}}$.

(b) Total CBD must be calculated as follows, where M is the mass or mass fraction of CBD and CBDA:

$M_{\text{total CBD}} = M_{\text{CBD}} + 0.877 \times M_{\text{CBDA}}$.

(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:

$P_{\text{total THC(dry)}} = P_{\text{total THC(wet)}} / [1-(P_{\text{moisture}}/100)]$

$P_{\text{total CBD(dry)}} = P_{\text{total CBD(wet)}} / [1-(P_{\text{moisture}}/100)]$

(6) Calculating RPD and RSD.

(a) A laboratory must use the following calculation for determining RPD:

RPD= *(sample result–duplicate result)(sample result+duplicate result2*

(b) A laboratory must use the following calculation for determining RSD:

% RSD= sx x100%

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, 475B.555.
Stats. Implemented: ORS 438.605, 438.610, 438.615 & 438.620, 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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) A test report must clearly identify for the licensee or registrant:

(a) Whether a sample has exceeded an action limit for an analyte in Exhibit A, Tables 3 or 4, or has otherwise failed a test as described in OAR 333-007-0300 to 333-007-0490.

(b) A "detected" pesticide result as required in section (6) of this rule.

(c) The batch unique identification number required under OAR 333-007-0350 and the test batch number associated with the samples tested, as required by OAR 333-064-0100.

(3) 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.

(4) The laboratory must report all test results required under OAR 333-007-0300 to 333-007-0490 that have not been reported under section (3) of this rule into the Commission's seed to sale tracking system if performing testing for a licensee.

(5) 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.

(6) 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 5:1 and meets identification criteria with a result of "detected."

(7) A laboratory must include in a test report the results of all associated batch quality control samples, with the date of analysis of the quality control samples and the acceptance limits used to determine acceptability.

(a) Batch quality control samples are the method blank and laboratory control sample.

(b) The report must clearly show the association to the client samples in the report by listing the batch identification numbers.

(8) A laboratory that is reporting failed test results to the Commission or the Authority in accordance with section (3) of this rule must report the failed test at the same time or before reporting to the licensee or registrant.

(9) If requested by the Authority, a laboratory must report aggregate information about numbers of tests performed, number of tests where analytes are detected but are below the action limits, and de-identified pesticide and solvent testing reports where a sample passed testing but with a "detected" as described in section (6) of this rule.

(10) 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17

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Rule Caption: Amendment of rules to adopt federal regulations by reference for the Lead-based Paint Program
Adm. Order No.: PH 36-2016
Filed with Sec. of State: 12-12-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 11-1-2016
Rules Adopted: 333-069-0100, 333-069-0120, 333-070-0200
Rules Repealed: 333-068-0005, 333-068-0010, 333-068-0015, 333-068-0020, 333-068-0025, 333-068-0030, 333-068-0035, 333-068-0040, 333-068-0045, 333-068-0050, 333-068-0055, 333-068-0060, 333-068-0065, 333-069-0005, 333-069-0010, 333-069-0015, 333-069-0020, 333-069-0030, 333-069-0040, 333-069-0050, 333-069-0060, 333-069-0070, 333-069-0080, 333-069-0090, 333-070-0075, 333-070-0080, 333-070-0085, 333-070-0090, 333-070-0095, 333-070-0100, 333-070-0105, 333-070-0110, 333-070-0125, 333-070-0130, 333-070-0135, 333-070-0140, 333-070-0150
Rules Ren. & Amend: 333-069-0085 to 333-069-0110, 333-070-0115 to 333-070-0210, 333-070-0120 to 333-070-0220, 333-070-0145 to 333-070-0230, 333-070-0160 to 333-070-0240
Subject: The Oregon Health Authority (Authority), Public Health Division, Environmental Public Health program is permanently adopting, amending and renumbering, and repealing administrative rules in chapter 333, divisions 68, 69 and 70 pertaining to the Lead-based Paint Program. The rule amendments will adopt by reference the Code of Federal Regulations (CFR) 40CFR Part 745 Subpart D and L. Recently, the U.S. Environmental Protection Agency (EPA) has notified the Authority that there are certain areas of the OARs that are not as stringent as the CFR. The Authority is adopting the CFR by reference so that its rules are essentially the same as the CFR, with the exception of fee and penalty sections.

During the 2015 legislative session, fee changes were legislatively approved as a part of the Authority's budget in SB 5526 (Oregon Laws 2015, chapter 838), and are now being updated in administrative rule. This included an increase in student fees from $17 to $50 per student. Changes were also made to individual and firm certification fees, which went from $85 for one year to $255 for a three year certification. The Authority was unsure if it would be keeping the Lead-based Paint Program or returning it to the EPA, so the fee changes were not incorporated into the text of the rules at the time. The Authority has decided to keep the program and is now incorporating the fee changes into the rule language.
Rules Coordinator: Brittany Hall—(971) 673-1291

333-069-0100
Federal Regulations Adopted by Reference

(1) The Oregon Health Authority (Authority) is authorized to administer the lead-based paint activities program under ORS 431A.355 and 40 Code of Federal Regulations (CFR) 745.324. The Authority's rules must be no less stringent than the U.S. Environmental Protection Agency's (EPA's) rules in 40 CFR 745 Subparts D and L.

(2) The Authority adopts by reference 40 CFR 745, Subpart D — Lead-Based Paint Hazards, and Subpart L — Lead-Based Paint Activities except as described in section (3) of this rule and except for:

(a) 40 CFR Part 745.225(g) and (h);

(b) 40 CFR 745.235;

(c) 40 CFR 745.237; and

(d) 40 CFR 745.239.

(3) Notwithstanding 40 CFR 745 Subpart D and L:

(a) All fees are as established in OAR 333-069-0120;

(b) All certification, recertification, accreditation and reaccreditation periods are as established in OAR 333-069-0120;

(c) Notices required to be sent to EPA under 40 CFR 745.225(c)(13)(vi) and (14)(iii) must be sent to the Authority at 800 NE Oregon Street, Suite 640, Portland, OR 97232 or to lead.program@state.or.us; and

(d) Where "Administrator" or "EPA" appears in 40 CFR Part 745, "OHA" or "Authority" is substituted, unless the context suggests otherwise.

Stat. Auth.: ORS 431A.355
Stats. Implemented: ORS 431A.355, 431A.358
Hist.: PH 36-2016, f. 12-12-16, cert. ef. 1-1-17

333-069-0110
Violations; Schedule of Penalties

(1) The Authority may assess civil penalties, or deny, suspend or revoke any accreditation or certification applied for or issued under these rules for any of the following violations:

(a) Level one violations:

(A) Offering to perform or performing lead-based paint activities without Authority certification and Oregon Construction Contractors Board (CCB) licensing, unless specifically exempted by these rules.

(B) Clearance examination inconsistencies including, but not limited to, the following:

(i) Failure to conduct clearance examination;

(ii) Allowing rehabitation before clearance has been achieved; or

(iii) Allowing rehabitation when lead hazard levels exceed the standard;

(C) The collection of samples as described in these rules by a non-certified individual or firm;

(D) Obtaining certification via fraud or duplication of certification documents;

(E) Conducting lead-based paint activities with a revoked, suspended or expired certification;

(F) Employing uncertified individuals to conduct lead-based paint activities;

(G) Failure to comply with a consent agreement or an administrative order;

(H) Falsification of results of lead-hazard sampling;

(I) Removing paint from target housing or child-occupied facilities without proper certification from the Authority; or

(J) Use of prohibited abatement methods.

(b) Level two violations:

(A) Failure to comply with prescribed work practice standards;

(B) Improper collection or handling of samples or sampling information collected for an inspection, risk assessment, clearance, or lead-hazard screen;

(C) Failure to use a National Lead Laboratory Accreditation Program laboratory for analysis of samples referred to in paragraph (1)(b)(B) of this rule;

(D) Incomplete, missing or late reports;

(E) Failure to provide notice of abatement, or notice given in a manner that obstructs proper oversight;

(F) Failure to provide client with report of lead-based paint activity in a timely manner, as specified for in these rules;

(G) Failure or refusal to establish, maintain, provide, copy, or permit access to records or reports as required; or

(H) Performance by a certified individual of lead-based paint activity outside of the scope of that individual's certification.

(c) Level three violations:

(A) Conducting lead-based paint activities without a valid certification badge;

(B) Conducting lead-based paint abatement without an occupant protection plan.

(2) If the Authority finds a violation of these rules that is not categorized in accordance with section (1) of this rule, the Authority, in its discretion, will determine what level the violation is depending on its severity and the extent to which the violation poses a risk to the public's health.

(3) Penalties will be assessed according to the following schedule:

(a) Level one violations:

(A) First offense: notice of noncompliance and a civil penalty of up to $1,000.

(B) Second offense: notice of noncompliance, a civil penalty of up to $3,000 and suspension of certification for up to 90 days.

(C) Third offense: notice of noncompliance, a civil penalty of up to $5000 and either suspension of certification for up to 180 days or revocation of certification.

(b) Level two violations:

(A) First offense: notice of noncompliance and a civil penalty of up to $500.

(B) Second offense: notice of noncompliance and a civil penalty of up to $2,000.

(C) Third offense: notice of noncompliance, a civil penalty of up to $5,000 and suspension of certification for up to 30 days.

(c) Level three violations:

(A) First offense: warning letter.

(B) Second offense: notice of noncompliance.

(C) Third offense: notice of noncompliance and a civil penalty of up to $100.

(4) The civil penalties in section (3) of this rule are per day per violation, not to exceed $5,000 for each violation.

(5) The Authority may revoke, suspend, or refuse to issue or reissue the certification of any individual or firm who fails to pay a civil penalty that has become due and payable.

(6) Notices of non-compliance, civil penalties, suspensions or revocations will be issued in accordance with ORS chapter 183.

Stat. Auth.: ORS 431A.355, 701.992
Stats. Implemented: ORS 431A.355, 701.992
Hist.: PH 8-2003, f. & cert. ef. 6-20-03; PH 22-2010(Temp), f. & cert. ef. 9-24-10 thru 3-22-11; Administrative correction 4-25-11; PH 4-2011, f. & cert. ef. 6-16-11; Renumbered from 333-069-0085, PH 36-2016, f. 12-12-16, cert. ef. 1-1-17

333-069-0120
Certification and Accreditation Periods; Fees

(1) Certifications and recertifications are issued for three years.

(2) Accreditations and reaccreditations are issued for one year.

(3) The following certification and recertification fees are established and are non-refundable:

(a) Firms: $255.

(b) Inspectors, risk assessors, supervisors, and project designers: $255.

(c) Workers: $150.

(4) The following initial accreditation fees are established and are non-refundable:

(a) Standard lead-based paint inspector or supervisor training course: $750.

(b) Standard lead-based paint risk assessor or worker training course: $500.

(c) Refresher lead-based paint activities training course covering more than two disciplines: $600.

(d) Inspector or supervisor refresher training course: $500.

(e) Risk assessor or a worker refresher training course: $350.

(f) Training manager for each standard training or refresher course: $175

(g) Each additional instructor or guest instructor for each standard training or refresher training course: $90.

(5) The following reaccreditation fees are established and are non-refundable:

(a) Standard lead-based paint activities training course for each discipline: $300.

(b) Refresher training course covering up to two disciplines: $100

(c) Refresher training course covering more than two disciplines: $200.

(d) Training Manager for each standard training or refresher course: $100:

(e) Each additional instructor or guest instructor for each standard training or refresher training course: $50.

(6) The application fee for a permit for painting shall be $5. This is an annual fee.

Stat. Auth.: ORS 431A.355
Stats. Implemented: ORS 431A.355
Hist.: PH 36-2016, f. 12-12-16, cert. ef. 1-1-17

333-070-0200
Federal Regulations Adopted by Reference

(1) The Oregon Health Authority (Authority) is authorized to administer the lead-based paint activities program under ORS 431A.355 and 40 Code of Federal Regulations (CFR) 745.324. The Authority's rules must be no less stringent than the U.S. Environmental Protection Agency's (EPA's) rules in 40 CFR 745 Subparts D, E and L.

(2) The Authority adopts by reference 40 CFR 745, Subpart D — Lead-Based Paint Hazards, Subpart E — Residential Property Renovation and Subpart L — Lead-Based Paint Activities except as described in section (3) of this rule and except for:

(a) 40 CFR Part 745.87;

(b) 745.91; and

(c) 745.225(g) and (h).

(3) Notwithstanding 40 CFR 745 Subparts D, E and L:

(a) All fees are as established in OAR 333-070-0220;

(b) All certification, recertification, accreditation and reaccreditation periods are as established in OAR 333-070-0220;

(c) Notices required to be sent to EPA under 40 CFR 745.225(c)(13)(vi) and (14)(iii) must be sent to the Authority at 800 NE Oregon Street, Suite 640, Portland, OR 97232 or lead.program@state.or.us; and

(d) Where "Administrator" or "EPA" appears in 40 CFR Part 745, "OHA" or "Authority" is substituted, unless the context suggests otherwise.

Stat. Auth.: ORS 431A.355
Stats. Implemented: ORS 431A.355, 431A.358
Hist.: PH 36-2016, f. 12-12-16, cert. ef. 1-1-17

333-070-0210
Inspections and Enforcement

(1) The Authority may:

(a) Enter private or public property at any reasonable time with consent of the owner or custodian of the property to inspect, investigate, evaluate or conduct tests or take specimens or samples for testing, as necessary to determine compliance with ORS 431A.355, 431A.358 or these rules;

(b) Issue subpoenas to determine compliance with ORS 431A.355, 431A.358 or these rules;

(c) Suspend or revoke a firm certification to perform renovation if the holder of the certification fails to comply with state or federal statutes or regulations related to lead-based paint;

(d) Suspend or revoke a certified renovator's certification if the renovator fails to comply with state or federal statutes or regulations related to lead-based paint; and

(e) Issue civil penalties per violation per day not to exceed $5,000 per violation per day for a violation of ORS 431A.355, 431A.358 or these rules, including but not limited to failure or refusal:

(A) To permit the Authority entry or inspection in accordance with this rule; or

(B) To establish and maintain records or to make available or permit access to or copying of records.

(2) In issuing civil penalties the Authority shall consider and document whether:

(a) The Authority made repeated attempts to obtain compliance;

(b) The firm or individual has a history of noncompliance with environmental statutes or regulations;

(c) The violation poses a serious risk to the public's health;

(d) The firm or individual gained financially from the noncompliance; and

(e) There are mitigating factors, such as a firm's or individual's cooperation with an investigation or actions to come into compliance.

(3) An individual or firm who is issued a notice of suspension, revocation or imposition of civil penalties shall have the right to a contested case hearing under ORS Chapter 183.

(4) The Authority shall maintain a publicly available list of individuals and firms whose certification has been suspended, revoked, or reinstated.

(5) Unless a final order specifies otherwise:

(a) An individual whose certification has been suspended must take a refresher training course (renovator or dust sampling technician) prior to certification being reinstated.

(b) An individual whose certification has been revoked shall take an initial renovator or dust sampling technician course in order to become certified again.

(c) A certified renovation firm whose certification has been revoked may reapply for certification after one year from the date of revocation.

Stat. Auth.: ORS 183.310-183.540, 183.745, 431A.355, 431A.358, 431A.363
Stats. Implemented: ORS 183.310-183.540, 183.745, 431A.355, 431A.358, 431A.363

Hist.: PH 8-2010, f. & cert. ef. 4-26-10; PH 4-2011, f. & cert. ef. 6-16-11; Renumbered from 333-070-0115, PH 36-2016, f. 12-12-16, cert. ef. 1-1-17

333-070-0220
Certification Fees and Refunds

(1) Firm certifications and recertifications are issued for five years.

(2) The following fees for certification and recertification for firms are established and are non-refundable:

(a) Firm certification: $250.

(b) Firm recertification: $250.

(3) Fee Waivers. A renovation firm that has applied to EPA for certification or is certified by the EPA may request a waiver of the certification fee if the firm:

(a) Is required to be certified by the Authority; and

(b) Provides documentation that the date of application to EPA for certification or the date of certification is prior to May 3, 2010.

(4) Refund policy.

(a) An incomplete application shall be returned with the application fee minus a $50 administration fee.

(b) If an applicant requests that a complete application be withdrawn within 30 days of its receipt by the Authority, the Authority shall refund the applicant $200 minus a $50 administration fee.

(c) No fees will be refunded if the Authority has begun to process an application.

(5) Lost certificate. A $15 fee will be charged for the replacement of a certified renovation firm certificate.

(6) Certificate replacement. Certified renovation firms seeking certificate replacement must submit the replacement application form and a payment of $15 in accordance with the instructions provided with the application package.

Stat. Auth.: ORS 431A.355
Stats. Implemented: ORS 431A.355
Hist.: PH 8-2010, f. & cert. ef. 4-26-10; PH 4-2011, f. & cert. ef. 6-16-11; Renumbered from 333-070-0120, PH 36-2016, f. 12-12-16, cert. ef. 1-1-17

333-070-0230
Suspending, Revoking, or Denying a Training Program's Accreditation; Civil Penalties

(1) The Authority may:

(a) Enter private or public property at any reasonable time with consent of the owner or custodian of the property to inspect or investigate as necessary to determine compliance with ORS 431A.355;

(b) Issue subpoenas to determine compliance with ORS 431A.355;

(c) Suspend, revoke, or deny an accreditation if the holder of the accreditation fails to comply with state or federal statutes or regulations related to lead-based paint; and

(d) Issue civil penalties not to exceed $5,000 per violation for a violation of ORS 431A.355, or any of these rules, including failure or refusal to permit entry or inspection in accordance with this rule.

(A) In issuing civil penalties the Authority shall consider whether:

(i) The Authority made repeated attempts to obtain compliance;

(ii) The training program has a history of noncompliance with environmental statutes or regulations;

(iii) The violation poses a serious risk to the public's health;

(iv) The training program gained financially from the noncompliance; and

(v) There are mitigating factors, such as the training program's cooperation with an investigation or actions to come into compliance.

(B) The Authority shall document its consideration of the factors in paragraph (1)(d)(A) of this rule.

(C) Each day a violation continues is an additional violation.

(D) A civil penalty imposed under this rule shall comply with ORS 183.745.

(2) An accredited training program that is issued a notice of suspension, revocation or denial shall have the right to a contested case hearing under ORS chapter 183.

(3) The Authority shall maintain a publicly available list of training programs whose accreditation has been suspended, revoked, denied, or reinstated.

(4) Unless a final order specifies otherwise:

(a) An accredited training program whose accreditation has been revoked may reapply for reaccreditation after one year from the date of revocation.

(b) If the training program's accreditation has been suspended and the suspension ends less than four years after the training program was initially accredited or reaccredited, the training program does not need to do anything to reactivate its accreditation once the period of suspension has expired.

Stat. Auth.: ORS 431A.355
Stats. Implemented: ORS 431A.355
Hist.: PH 8-2010, f. & cert. ef. 4-26-10; PH 4-2011, f. & cert. ef. 6-16-11; Renumbered from 333-070-0145, PH 36-2016, f. 12-12-16, cert. ef. 1-1-17

333-070-0240
Accreditation Fees

(1) Accreditations and reaccreditations are issued for four years.

(2) The following accreditation and reaccreditation fees are established and are non-refundable:

(a) Renovator Initial — $560 — $340:

(b) Dust Sampling Technician Initial — $560 — $340:

(c) Renovator Refresher — $400 — $310:

(d) Dust Sampling Technician Refresher — $400 — $310

(2) Student Fee Schedule, Course — Fee:

(a) Renovator Initial — $50:

(b) Renovator Refresher — $50:

(c) Dust Sampling Technician Initial — $50:

(d) Dust Sampling Refresher — $50.

(e) The student fee is to be paid by the training program at the completion of each training course. The $50 fee is per student that successfully completes the course. The fee shall be paid by the training program to the Authority within 10 days after completion of the training course.

(4) Training programs with current accreditation by EPA or an EPA-authorized state or tribal program shall pay a prorated fee of the appropriate fee listed above, divided by 48, times the number of months remaining in the current accreditation, beginning with the month following application to the Authority.

Stat. Auth.: ORS 431A.355
Stats. Implemented: ORS 431A.355
Hist.: PH 8-2010, f. & cert. ef. 4-26-10; PH 4-2011, f. & cert. ef. 6-16-11; Renumbered from 333-070-0160, PH 36-2016, f. 12-12-16, cert. ef. 1-1-17

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Rule Caption: Dental Pilot Projects
Adm. Order No.: PH 37-2016
Filed with Sec. of State: 12-12-2016
Certified to be Effective: 12-12-16
Notice Publication Date: 11-1-2016
Rules Amended: 333-010-0405, 333-010-0415, 333-010-0435
Subject: The Oregon Health Authority, Public Health Division, Oral Health Program is permanently amending administrative rules in chapter 333, division 10 to add requirements for project evaluation and define the term "evaluator" for the purposes of the project evaluation. Additionally, the amended rules will allow for Coordinated Care Organizations to apply as a sponsor of a Dental Pilot Project. These rules provide administrative oversight of Dental Pilot Projects as defined in SB 738 (2011 OL, Ch. 716), which passed during the 2011 legislative session. The rule amendments provide administrative guidance to the required content of Dental Pilot Projects evaluation and monitoring requirements. The allowance of Coordinated Care Organizations is in keeping current with health transformation in Oregon. Coordinated Care Organizations were formally enacted into law after the original administrative rules for the Dental Pilot Projects were written.
Rules Coordinator: Brittany Hall—(971) 673-1291

333-010-0405
Dental Pilot Projects: Definitions

For purposes of OAR 333-010-0400 through 333-010-0470, the following definitions apply:

(1) "Authority" means the Oregon Health Authority.

(2) "Clinical phase" means instructor supervised experience with a patient during which a trainee applies knowledge presented by an instructor.

(3) "Didactic phase" means an organized body of knowledge presented by an instructor.

(4) "Director" means the Public Health Director within the Oregon Health Authority, or his or her designee.

(5) "Employment/Utilization Phase" means ongoing application of didactic and clinical knowledge and skills in an employment setting under the supervision of a supervisor.

(6) "Employment/Utilization Site" means a health facility, any clinical setting where health care services are provided, and the facilities or programs described in ORS 680.205(1).

(7) "Evaluator" means an individual who will conduct an evaluation of the pilot project and is unaffiliated with the project and who has no financial or commercial interest in the project's outcome.

(8) "Instructor" means a person qualified to practice or teach the knowledge or skills a trainee is to learn.

(a) "Clinical instructor" is a person who is certified or licensed in the field for which clinical instruction is occurring.

(b) "Non-clinical instructor" is a person with specific training or expertise as demonstrated through a degree or years of experience relevant to the content of instruction.

(9) "Program" means the Dental Pilot Projects program administered by the Authority.

(10) "Program staff" means the staff of the Authority with responsibility for the program.

(11) "Project" means a Dental Pilot Project approved by the director or delegate.

(12) "Project director" means the individual designated by the sponsor to have responsibilities for the conduct of the project staff, instructors, supervisors, and trainees.

(13) "Reviewer" means an individual designated by program staff to review and comment on all or portions of a project application.

(14) "Sponsor" means an entity putting forth an application for a dental pilot project.

(15) "These rules" means OAR 333-010-0400 through 333-010-0470.

(16) "Training program" means an organized educational program that includes at least a didactic phase, clinical phase, and usually an employment/utilization phase.

Stat. Auth.: 2011 OL Ch. 716
Stats. Implemented: 2011 OL Ch. 716
Hist.: PH 5-2013, f. & cert. ef. 2-4-13; PH 37-2016, f. & cert. ef. 12-12-16

333-010-0415
Dental Pilot Projects: Application Procedure

(1) A sponsor may submit an application for a dental pilot project on a form prescribed by the Authority.

(2) The application must demonstrate how the pilot project will comply with the requirements of these rules.

(3) An application must include, but is not limited to the following information:

(a) Sponsors:

(A) A description of the sponsor, including a copy of an organizational chart that identifies how the project relates organizationally to the sponsor;

(B) A copy of a document verifying the sponsor's status as a non-profit educational institution, professional dental organization, or community hospital or clinic, coordinated care organization or dental care organization;

(C) A description of the functions of the project director, instructors, and other project staff;

(D) The funding sources for the project; and

(E) Documentation of liability insurance relevant to services provided by trainees.

(b) Trainee information:

(A) The criteria that will be used to select trainees; and

(B) The number of proposed trainees.

(c) Instructor/Supervisor information:

(A) The criteria used to select instructors and supervisors;

(B) Instructor-to-trainee ratio;

(C) The background of instructors in training techniques and methodology;

(D) The number of proposed supervisors; and

(E) The criteria used to select an employment/utilization site.

(d) Costs:

(A) The average cost of preparing a trainee, including but not limited to the cost information related to instruction, instructional materials and equipment, space for conducting didactic and clinical phases, and other pertinent costs;

(B) The predicted average cost per patient visit for the care rendered by a trainee; and

(C) A budget narrative that lists costs associated with key project areas, including but not limited to:

(i) Personnel and fringe benefits for project director, instructors, and staff associated with the project;

(ii) Contractors and consultants to the project;

(iii) Materials and supplies used in the clinical, didactic, and employment/utilization phases of the project;

(iv) Equipment and other capital costs associated with the project; and

(v) Travel required for implementing and monitoring the project.

Stat. Auth.: 2011 OL Ch. 716
Stats. Implemented: 2011 OL Ch. 716
Hist.: PH 5-2013, f. & cert. ef. 2-4-13; PH 37-2016, f. & cert. ef. 12-12-16

333-010-0435
Dental Pilot Projects: Evaluation and Monitoring

(1) Evaluation Plan. A sponsor of a dental pilot project must have an evaluation plan approved by the Authority that includes, but is not limited to the following:

(a) A description of the baseline data and information collected about the availability or provision of oral health care delivery, or both, prior to utilization of the trainee;

(b) A description of baseline data and information to be collected about trainee performance, acceptance among patient and community, and cost effectiveness;

(c) A description of methodology to be used in collecting and analyzing the data about trainee performance, acceptance, and cost effectiveness;

(d) A provision for reviewing and modifying objectives and methodology at least annually; and

(e) Identification of an evaluator unaffiliated with the project and with no financial or commercial interest in the outcome of the project that will conduct the pilot project's evaluation.

(2) Monitoring Plan. A sponsor of a dental pilot project must have a monitoring plan approved by the Authority that ensures at least quarterly monitoring and describes how the sponsor will monitor and ensure:

(a) Patient safety;

(b) Trainee competency;

(c) Supervisor fulfillment of role and responsibilities; and

(d) Employment/utilization site compliance.

(3) Data. A sponsor's evaluation and monitoring plans must describe:

(a) How data will be collected;

(b) How data will be monitored for completeness; and

(c) How data will be protected and secured.

(4) A sponsor must permit project staff or their designees to visit each employment/utilization site at least monthly during the first six month period and at least quarterly thereafter.

(5) A sponsor must provide a report of information requested by the program in a format and timeframe requested.

(6) A sponsor must report adverse events to the program the day they occur.

(7) A dental pilot project must re-submit its evaluation and monitoring plan by January 2, 2017 for review and approval by the Authority.

(a) If the Authority determines that an evaluation or monitoring plan does not comply with these rules the Authority must notify the sponsor of any deficiencies and provide a deadline for the sponsor to resubmit the plan.

(b) If a sponsor does not submit an evaluation or monitoring plan that complies with these rules, after being given an opportunity to correct the deficiencies, the sponsor may be subject to suspension or termination in accordance with OAR 333-010-0470.

(c) The Authority shall notify a sponsor of its approval of an evaluation or monitoring plan.

Stat. Auth.: 2011 OL Ch. 716
Stats. Implemented: 2011 OL Ch. 716
Hist.: PH 5-2013, f. & cert. ef. 2-4-13; PH 37-2016, f. & cert. ef. 12-12-16

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Rule Caption: Cannabis Testing and Labeling
Adm. Order No.: PH 38-2016(Temp)
Filed with Sec. of State: 12-13-2016
Certified to be Effective: 12-15-16 thru 5-30-17
Notice Publication Date:
Rules Amended: 333-007-0090, 333-007-0320, 333-007-0350, 333-007-0360, 333-007-0440, 333-064-0100, 333-064-0110
Subject: The Oregon Health Authority, Public Health Division, Oregon Medical Marijuana Program is temporarily amending administrative rules in chapter 333, divisions 7 and 64 pertaining to testing.

The Oregon Health Authority establishes rules and standards for the testing of marijuana items. As of October 1, 2016, all marijuana items must be tested to standards outlined in division 7 and division 64 of the testing rules. These temporary rules reduce the regulatory burden and costs of testing marijuana for registered and licensed mar-

ijuana growers, producers and processors. The temporary rules will likely reduce regulatory costs that will in effect increase market access of marijuana items to consumers and medical marijuana patients while still ensuring the implementation of statutorily required testing standards. In addition, these rules amend test result reporting requirements for laboratories so that the Authority can ensure that marijuana and marijuana items are safe for consumers and medical marijuana patients. The temporary rules increase the maximum number of units allowed in a cannabinoid product process lot, amend the requirements for sampling of batches of usable marijuana, amend the number of sample increments that must be taken for testing of cannabinoid concentrates, extracts and products, delay when laboratories must begin reporting quality control information on test results and update the sampling protocols to be consistent with the rule changes.

Rules Coordinator: Brittany Hall—(971) 673-1291

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.

(c) May:

(A) Use a peel-back or accordion label with the information required in subsection (4)(b) of this rule, if the peel-back or accordion label can be easily identified by a patient or consumer as containing important information.

(B) Use 6 point font for the information listed in paragraph (4)(a)(A) to (D) of this rule.

(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, plus or minus five percent.

(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."

(15) Effective January 1, 2017, a cartridge containing a cannabinoid concentrate, extract or product intended for use with an inhalant delivery system as that is defined in ORS 431.840 is not required to be labeled in accordance with these rules except that the cartridge must have a label with the universal symbol. All the remaining label requirements must be included on the packaging that is used to display the cartridge for sale or transfer.

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; PH 33-2016, f. & cert. ef. 11-28-16; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17; PH 38-2016(Temp), f. 12-13-16, cert. ef. 12-15-16 thru 5-30-17

333-007-0320

Testing Requirements for Marijuana or Usable Marijuana

(1) A producer or grower must test every batch from a 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 batch from a 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 batch from 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17; PH 38-2016(Temp), f. 12-13-16, cert. ef. 12-15-16 thru 5-30-17

333-007-0350
Batch Requirements

(1) Usable marijuana. A producer or grower must separate each harvest lot into no larger than 10 pound batches.

(2) Cannabinoid concentrates and extracts.

(a) A process lot is considered a batch.

(b) The size of a process lot submitted for sampling and testing for purposes of a control study under OAR 333-007-0440 defines the maximum process lot for that concentrate, extract or product for purposes of sampling and testing after a control study has been certified.

(3) Cannabinoid products. A processor or processing site must separate process lots into not larger than 35,000 unit batches.

(4) 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.

(5) 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17; PH 38-2016(Temp), f. 12-13-16, cert. ef. 12-15-16 thru 5-30-17

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).

(c) A portion of samples taken from multiple batches of usable marijuana may be combined for purposes of testing for THC and CBD if the batches are the same strain, regardless of the size of the multiple batches.

(d) A portion of samples taken from multiple batches of usable marijuana may be combined for purposes of testing for pesticides if the multiple batches in total do not exceed 10 pounds. If the combined samples fail for pesticides all the batches fail.

(2) Cannabinoid concentrates, extracts and products.

(a) At a minimum, samples must be taken in increments established in Exhibit B, incorporated by reference. Enough samples from a batch must be taken to ensure that the required attributes in the batch to be tested are homogenous and must be taken in a manner consistent with the laboratory's accredited sampling policies and procedures described in OAR 333-064-0100(2).

(b) If a cannabinoid concentrate, extract or product has successfully passed a control study, future batches of that concentrate, extract or product with a control study certification, as described in OAR 333-007-0440, may have samples collected in increments prescribed in Exhibit B, Table 7 or 8, as applicable, and the sample increments may be combined into a field primary sample and a field duplicate sample in accordance with OAR 333-007-0440 and OAR 333-064-0100(2). Both the field primary and the field duplicate samples must be tested and may not be combined.

(3) Sufficient sample size must be taken for analysis of all required tests and the quality control performed by the testing laboratory for these tests.

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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17; PH 38-2016(Temp), f. 12-13-16, cert. ef. 12-15-16 thru 5-30-17

333-007-0440
Control Study

(1) A laboratory may perform a control study on a process lot 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 a control study; and

(b) For cannabinoid products, the expected THC range for the product.

(2) Samples taken for purposes of a control study 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 a control study 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 by more than 5 percent 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 a control study has passed for any of the following, and must send the form at the client's request to the Authority or the Commission:

(a) Pesticides, if applicable.

(b) Solvents, if applicable.

(c) THC concentration as calculated pursuant to OAR 333-064-0100, if applicable.

(7) A control study fails if:

(a) Any sample exceeds an action limit in OAR 333-007-0400 or 333-007-0410. A sample that exceeds an action limit may not be reanalyzed and retested under OAR 333-007-0450(1) unless the laboratory determines that the result is due to laboratory error.

(b) The amount of THC, as calculated pursuant to OAR 333-064-0100, between samples taken from the batch exceeds 30 percent RSD.

(c) The amount or percentage of THC as calculated pursuant to OAR 333-064-0100, exceeds the maximum concentration limit permitted in a package by more than 5 percent as specified in OAR 333-007-0200 to 333-007-0220, as applicable.

(8) A process lot sampled and tested for purposes of a control study may be sold or transferred if the samples pass all the required tests.

(9) If a cannabinoid concentrate, extract or product successfully passes a control study the following apply to sampling of future batches for one year:

(a) Sample increments may be collected and combined into a primary sample and a field duplicate sample as described in OAR 333-007-0360, Example B, Table 7 or 8, as applicable, OAR 333-064-0100, and ORELAP-SOP-002 Rev. 3.1.

(b) The primary sample and the field sample must be tested and may not be combined.

(10) The certification of a control study is invalidated if a processor or processing site makes any changes:

(a) To the standard operating procedures for that product.

(b) In the type of ingredient in the product.

(11) For purposes of section (10) of this rule it is not considered a change to standard operating procedures or a change in the type of ingredient if the processor or processing site is using:

(a) Different strains of usable marijuana in batches.

(b) An ingredient with a different level of purity as long as the purity of the ingredient complies with the Authority's or the Commission's processing rules.

(c) Different flavors or colors in batches, as long as the different flavors or colors do not have an effect on the potency of the product.

(12) The Authority will certify a control study for registrants. The Commission will certify a control study for licensees.

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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17; PH 38-2016(Temp), f. 12-13-16, cert. ef. 12-15-16 thru 5-30-17

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 3.0; and

(B) Concentrates, Extracts, and Products: ORELAP-SOP-002 Rev 3.1.[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 a control study or has not yet gone through a control study.

(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:

$M_{\text{total delta-9 THC}} = M_{\text{delta-9 THC}} + 0.877 \times M_{\text{delta-9 THCA}}$.

(b) Total CBD must be calculated as follows, where M is the mass or mass fraction of CBD and CBDA:

$M_{\text{total CBD}} = M_{\text{CBD}} + 0.877 \times M_{\text{CBDA}}$.

(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:

$P_{\text{total THC(dry)}} = P_{\text{total THC(wet)}} / [1-(P_{\text{moisture}}/100)]$

$P_{\text{total CBD(dry)}} = P_{\text{total CBD(wet)}} / [1-(P_{\text{moisture}}/100)]$

(6) Calculating RPD and RSD.

(a) A laboratory must use the following calculation for determining RPD:

RPD= *(sample result–duplicate result)(sample result+duplicate result2*

(b) A laboratory must use the following calculation for determining RSD:

% RSD= sx x100%

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, 475B.555.

Stats. Implemented: ORS 438.605, 438.610, 438.615 & 438.620, 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17; PH 38-2016(Temp), f. 12-13-16, cert. ef. 12-15-16 thru 5-30-17

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) A test report must clearly identify for the licensee or registrant:

(a) Whether a sample has exceeded an action limit for an analyte in Exhibit A, Tables 3 or 4, or has otherwise failed a test as described in OAR 333-007-0300 to 333-007-0490.

(b) A "detected" pesticide result as required in section (6) of this rule.

(c) The batch unique identification number required under OAR 333-007-0350 and the test batch number associated with the samples tested, as required by OAR 333-064-0100.

(3) 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.

(4) The laboratory must report all test results required under OAR 333-007-0300 to 333-007-0490 that have not been reported under section (3) of this rule into the Commission's seed to sale tracking system if performing testing for a licensee.

(5) 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.

(6) 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 5:1 and meets identification criteria with a result of "detected."

(7) After January 31, 2017, a laboratory must include in a test report the results of all associated batch quality control samples, with the date of analysis of the quality control samples and the acceptance limits used to determine acceptability.

(a) Batch quality control samples are the method blank and laboratory control sample.

(b) The report must clearly show the association to the client samples in the report by listing the batch identification numbers.

(8) A laboratory that is reporting failed test results to the Commission or the Authority in accordance with section (3) of this rule must report the failed test at the same time or before reporting to the licensee or registrant.

(9) If requested by the Authority, a laboratory must report aggregate information about numbers of tests performed, number of tests where analytes are detected but are below the action limits, and de-identified pesticide and solvent testing reports where a sample passed testing but with a "detected" as described in section (6) of this rule.

(10) 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; PH 35-2016(Temp), f. & cert. ef. 12-2-16 thru 5-30-17; PH 38-2016(Temp), f. 12-13-16, cert. ef. 12-15-16 thru 5-30-17

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Oregon Housing and Community Services Department
Chapter 813

Rule Caption: Adds General Housing Account as department housing program, amends definitions; clarifies process for submitting protests

Adm. Order No.: OHCS 15-2016

Filed with Sec. of State: 12-14-2016

Certified to be Effective: 12-14-16

Notice Publication Date: 11-1-2016

Rules Adopted: 813-005-0025

Rules Amended: 813-005-0005

Rules Repealed: 813-005-0005(T), 813-005-0025(T)

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 (Notice of Funding Availability). The rules also adds a definition for regulatory agreement as to project management or management agreement. A new rule is adopted to establish the process for an applicant or potential qualifying applicant to protest or challenge the solicitation process for 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; OHCS 15-2016, f. & cert. ef. 12-14-16

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; OHCS 15-2016, f. & cert. ef. 12-14-16

Oregon Liquor Control Commission
Chapter 845

Rule Caption: The amendments re-organize the rule, clearly define violation sanctions and clarify aggravating and mitigating circumstances.

Adm. Order No.: OLCC 20-2016

Filed with Sec. of State: 11-30-2016

Certified to be Effective: 12-1-16

Notice Publication Date: 10-1-2016

Rules Amended: 845-006-0500

Subject: This rule describes the various sanctions the Commission imposes on licensees, including cancellation or suspension of a license, and civil penalties. The amendments re-organize the rule and clearly define violation sanctions. Further, the amendments clarify aggravating and mitigating circumstances.

Rules Coordinator: Bryant Haley—(503) 872-5136

845-006-0500

Suspensions and Civil Penalties

(1) The Commission cancels or suspends a license under its authority in:

(a) ORS 471.315 for violations of any provision of ORS Chapter 471 or any administrative rule (chapter 845) the Commission adopts pursuant to these chapters;

(b) ORS 459.992(4) for violations of any provision of 459A.705, 459A.710 or 459A.720 or any administrative rule the Commission adopts pursuant to these statutes;

(c) ORS 471.315(1)(d) for public interest or necessity reasons.

(2) The Commission cancels or suspends a service permit under its authority in ORS 471.385 for violations of Chapter 471 or any administrative rule (chapter 845) the Commission adopts pursuant to these chapters.

(3) The Commission cancels or suspends an alcohol server education provider certificate under its authority in ORS 471.547.

(4) ORS 471.322 and 471.327 allow the Commission to impose a civil penalty instead of suspension. In most cases, the Commission allows the licensee or permittee the option of serving the suspension or paying the civil penalty.

(5) ORS 471.315 allows the Commission to impose either a suspension or a civil penalty or both. The Commission imposes mandatory suspensions when necessary to ensure future licensee, permittee, or patron compliance.

(6) ORS 471.322 and 471.327 limit the amount of a civil penalty the Commission may impose. To stay within these limits, the Commission usually computes civil penalties by multiplying the number of days in the suspension by $165 for retail, manufacturer, and wholesale licensees, and by $25 for service permittees.

(7) The Commission uses the following violation categories:

(a) I — Violations that make licensee ineligible for a license;

(b) II — Violations that create an immediate threat to public health or safety;

(c) II(a) — Violations for unlawful drug activity;

(d) III — Violations that create a potential threat to public health or safety OR violations of the tied house or financial assistance prohibitions;

(e) III(a) — Violations for the sale of alcohol to a minor or failure to check identification when the retail licensee qualifies under the Responsible Vendor Program;

(f) IV — Violations that create a climate conducive to abuses associated with the sale or service of alcoholic beverages;

(g) V — Violations inconsistent with the orderly regulation of the sale or service of alcoholic beverages.

(8) Violation sanctions

(a) The Commission may sanction a licensee or permittee in accordance with the guidelines set forth in Exhibit 1. Exhibit 1 also gives 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 subsection (7) 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 cancellation.

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 patron or employee.

(G) A violation involving a juvenile.

(H) A violation resulting in injury or death.

(I) 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.

(9) A licensee may not avoid the sanction for a violation or the application of the provision for successive violations by merely 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.

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

Stat. Auth.: ORS 471, including 471.030, 471.040, 471.730(1) & (5)

Stats. Implemented: ORS 471.315, 471.322 & 471.327

Hist.: OLCC 19-2000, f. 12-6-00, cert. ef. 1-1-01; OLCC 21-2007, f. 9-27-07, cert. ef. 10-1-07; OLCC 4-2009, f. 4-21-09, cert. ef. 5-1-09; OLCC 20-2016, f. 11-30-16, cert. ef. 12-1-16

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Rule Caption: The rule adopts the Special Events Brewery License as set forth in House Bill 4053.
Adm. Order No.: OLCC 21-2016
Filed with Sec. of State: 12-6-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 9-1-2016
Rules Adopted: 845-005-0412
Subject: House Bill 4053 passed during the 2016 Legislative session. It becomes effective on January 1, 2017 and will allow a Brewery licensee to obtain a special events brewery (SEB) license. The SEB license will also allow:

1. Retail sales of malt beverages, wine, and cider for consumption on or off the licensed premises; and

2. Retail sales of malt beverages, wine, and cider in a securely covered container (growler).

Rules Coordinator: Bryant Haley—(503) 872-5136

845-005-0412
Special Events Brewery License

Section 2, Chapter 3, Oregon Laws 2016 authorizes the Commission to issue a Special Events Brewery (SEB) license to an Oregon Brewery licensee. This rule sets the qualifications and requirements for a Special Events Brewery license.

(1) Definitions.

(a) "Bar" means a counter at which the preparation, pouring, serving, sale, or consumption of alcoholic beverages is the primary activity;

(b) "Food counter" means a counter in an area in which minors are allowed and at which the primary activity at all times is the preparation, serving, sale, or consumption of food;

(c) "License day" means from 7:00 am until 2:30 am on the succeeding calendar day. The license fee is $10.00 per license day or any part of a license day.

(d) "Serious violation history" means:

(A) Two or more category III or IIIa administrative violations of any type, or category IV violations involving minors. However, if the circumstances of a violation include aggravation, one violation may be sufficient; or

(B) One category I, II, or IIa administrative violation; or

(C) Two or more crimes or offenses involving liquor laws.

(e) "Social game" means a game other than a lottery, if authorized by a local county or city ordinance pursuant to ORS 167.121, between players in a private business, private club, or place of public accommodation where no house player, house bank, or house odds exist and there is no house income from the operation of the social game.

(f) "Video lottery game" means a video lottery game terminal authorized by the Oregon State Lottery. Examples include but are not limited to video poker and video slots. Keno monitors are not considered a video lottery game.

(2) Only the holder of a Brewery license issued under ORS 471.220 may qualify for a SEB license. The SEB license is only for a location other than that designated as the Brewery licensee's annually licensed premises and may allow the licensee to:

(a) Sell wine, malt beverages and cider at retail for consumption on or off the licensed premises;

(b) Sell, in securely covered containers supplied by the consumer and having a capacity of not more than two gallons each, wine, malt beverages, or cider for off-premises consumption.

(3) The Commission will not approve more than five license days on a single application. The Commission may limit approval of any application to a single license day or to any number of license days fewer than five days.

(4) Applicants must apply in writing for an SEB license, using the application form provided by the Commission. The Commission may require additional forms, documents, or information as part of the application. The Commission may refuse to process any application not complete, not accompanied by the documents or disclosures required by the form or the Commission, or that does not allow the Commission sufficient time to investigate it. Sufficient time is typically one to three weeks prior to the event date. The Commission may 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 proceeding under ORS 183.310 to 183.550.

(5) The application for a SEB license under this rule shall include:

(a) A written, dated, and signed plan the Commission determines adequately manages:

(A)The event to prevent problems and violations;

(B) Patronage by minors as set out in subsection (6) of this rule; and

(C) Alcohol consumption by adults.

NOTE: An application is not complete if this plan is not approved by the Commission. The Commission may use subsection (4) of this rule to refuse to process any application that is not complete;

(b) Identification of the individuals to be employed by the licensee to manage events on the SEB licensed premises;

(c) Identification of the premises or area proposed to be licensed;

(d) Menu and proposal showing compliance with the food service standards of OAR 845-006-0465(2)–(4);

(e) Statement of the type of event to be licensed, type and extent of entertainment to be offered, expected patronage overall and by minors, type of food service to be offered, proposed hours of food service, and proposed hours of operation;

(f) The recommendation in writing of the local governing body where the licensed premises will be located; and

(g) License fees as established by ORS 471.311.

(6) A plan for managing patronage by minors under subsection (5)(a) of this rule must meet the following requirements:

(a) If the SEB license will be on any part of a premises, room, or area with an annual license issued by the Commission, the Commission must be convinced that the plan will follow the minor posting and control plan, including any temporary relaxation of the minor posting, assigned to that premises, room, or area under the annual license. The Commission must also be convinced that the plan will prevent minors from gaining access to alcoholic beverages and any portion of the licensed premises prohibited to minors.

(b) If the SEB license will not be on any part of a premises, room, or area with an annual license issued by the Commission, the Commission must be convinced that the plan will prevent minors from gaining access to alcoholic beverages and any portion of the licensed premises the Commission prohibits to minors.

(7) Minors are prohibited from the SEB licensed premises or portions of the licensed premises as follows:

(a) Minors may not sit or stand at a bar; however, minors may sit or stand at a food counter;

(b) Minors may not be in an area where there are video lottery games, social games, or nude entertainment or where such activities are visible;

(c) Minors may not be in an area where the licensee's approved written plan designates that minors will be excluded.

(8) The Commission may deny, cancel or restrict a SEB license for any reason for which the Commission may deny, cancel or restrict a regular license.

(9) The Commission may deny or restrict a SEB license if the applicant has a serious violation history at events previously licensed with a special license within the past 36 months.

(10) The Commission may refund the SEB license fee if the application is withdrawn by the applicant or denied by the Commission, or if the event does not take place because of circumstances beyond the licensees control, or if the Commission determines the applicant does not need a license for the event proposed in the application.

(11) When the Commission approves a written plan under subsection (5)(a) of this rule, the licensee must follow that written plan. Failure to follow that written plan is a Category III violation.

(12) If the licensee fails to prevent minors from gaining access to alcoholic beverages or fails to prevent minors from gaining access to any portion of the licensed premises prohibited to minors, the Commission may immediately prohibit minors from the licensed premises or portion(s) of the premises.

Stat. Auth.: ORS 471.040
Stats. Implemented: Sec. 2, Ch, 3, OL 2016
Hist.: OLCC 21-2016, f. 12-6-16, cert. ef. 1-1-17

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Oregon Public Employees Retirement System
Chapter 459

Rule Caption: Housekeeping edits reflect changes from recent legislative sessions and new Social Security annual compensation limits.
Adm. Order No.: PERS 6-2016
Filed with Sec. of State: 11-18-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 10-1-2016
Rules Amended: 459-017-0060
Subject: By statute, a Tier One or Tier Two retired member who returns to PERS-covered employment may continue to receive their retirement benefits so long as they work less than 1,040 hours in a calendar year. However, hour limits are not imposed on retired members who qualify for certain exceptions provided in statute.

During the 2015 and 2016 legislative sessions, three bills were adopted regarding the statutory exceptions to the hourly limit. A summary of those bills is provided below:

House Bill 2684 (2015) extended return-to-work exceptions for Tier One and Tier Two retired members who are employed by public employers as nursing instructors or as trainers for the Department of Public Safety Standards and Training (DPSST). The exception was scheduled to expire January 2, 2016, but was extended to January 2, 2026.

House Bill 3058 (2015) established a new exception to the hourly limitation for retired Tier One and Tier Two retired members who are re-employed by school districts or education service districts as teachers of career and technical education (CTE). Retired members must be certified by the Teacher Standards and Practices Commission (TSPC) as teachers of CTE. The exception is effective from June 18, 2015, through June 30, 2018.

House Bill 4022 (2016) reinstated the exemption that had expired for Tier One or Tier Two retired members who are employed by school districts or education service districts to provide services as speech-language pathologists or speech-language pathologist assistants. The bill applies to hours worked by retired members on or after January 1, 2016, and expires January 2, 2026.

In addition, staff added the existing exception provided in Oregon Revised Statutes (ORS) 238.088, which had been inadvertently omitted. This exception allows certain appointed public officials to work unlimited hours if they are elected or appointed in a county with a population of fewer than 75,000 inhabitants, under certain conditions.

Finally, staff updated the federal Social Security annual compensation limits on earnings for 2017, which were recently published in October 2016. Under ORS 238.082(3), retired members receiving benefits under the Social Security Act may be employed for up to the number of hours for which their salary equals the annual Social Security compensation limit, or up to 1040, whichever is greater.
Rules Coordinator: Daniel Rivas—(503) 603-7713

459-017-0060
Reemployment of Retired Members

(1) For purposes of this rule, "retired member" means a member of the PERS Chapter 238 Program who is retired for service.

(2) Reemployment under ORS 238.082. A retired member may be employed under ORS 238.082 by a participating employer without loss of retirement benefits provided:

(a) The period or periods of employment with one or more participating employers total less than 1,040 hours in a calendar year; or

(b) If the retired member is receiving retirement, survivors, or disability benefits under the federal Social Security Act, the period or periods of employment total less than either 1,040 hours in a calendar year, or the total number of hours in a calendar year that, at the retired member's specified hourly rate of pay, would cause the annual compensation of the retired member to exceed the following Social Security annual compensation limits, whichever is greater.

(A) For retired members who have not reached full retirement age under the Social Security Act, the annual compensation limit is $16,920; or

(B) For the calendar year in which the retired member reaches full retirement age under the Social Security Act and only for compensation for the months before reaching full retirement age, the annual compensation limit is $44,880.

(3) The limitations on employment in section (2) of this rule do not apply if the retired member has reached full retirement age under the Social Security Act.

(4) The limitations on employment in section (2) of this rule do not apply if:

(a) The retired member meets the requirements of ORS 238.082(4), (5), (6), (7) or (8), and did not retire at a reduced benefit under the provisions of ORS 238.280(1), (2) or (3);

(b) The retired member retired at a reduced benefit under ORS 238.280(1), (2) or (3), is employed in a position that meets the requirements of ORS 238.082(4), the date of employment is more than six months after the member's effective retirement date, and the member's retirement otherwise meets the standard of a bona fide retirement;

(c) The retired member is employed by a school district or education service district as a speech-language pathologist or speech-language pathologist assistant and:

(A) The retired member did not retire at a reduced benefit under the provisions of ORS 238.280(1) or (3); or

(B) If the retired member retired at a reduced benefit under the provisions of ORS 238.280(1) or (3), the retired member is not so employed until more than six months after the member's effective retirement date and the member's retirement otherwise meets the standard of a bona fide retirement;

(d) The retired member meets the requirements of section 2, chapter 499, Oregon Laws 2007, as amended by section 1, chapter 108, Oregon Laws 2015;

(e) The retired member meets the requirements of section 2, chapter 475, Oregon Laws 2015;

(f) The retired member is employed for service during a legislative session under ORS 238.092(2);

(g) The retired member meets the requirements of ORS 238.088(2), and did not retire at a reduced benefit under the provisions of ORS 238.280(1), (2) or (3); or

(h) The retired member is on active state duty in the organized militia and meets the requirements under ORS 399.075(8).

(5) For purposes of population determinations referenced by statutes listed in this rule, the latest federal decennial census shall first be operative on the first day of the second calendar year following the census year.

(6) For purposes of ORS 238.082(6), a retired member replaces an employee if the retired member:

(A) Is assigned to the position of the employee; and

(B) Performs the duties of the employee or duties that might be assigned to an employee in that position.

(7) If a retired member is reemployed subject to the limitations of ORS 238.082 and section (2) of this rule, the period or periods of employment subsequently exceed those limitations, and employment continues into the month following the date the limitations are exceeded:

(a) If the member has been retired for six or more calendar months:

(A) PERS will cancel the member's retirement.

(i) If the member is receiving a monthly service retirement allowance, the last payment to which the member is entitled is for the month in which the limitations were exceeded.

(ii) If the member is receiving installment payments under ORS 238.305(4), the last installment payment to which the member is entitled is the last payment due on or before the last day of the month in which the limitations were exceeded.

(iii) If the member received a single lump sum payment under ORS 238.305(4) or 238.315, the member is entitled to the payment provided the payment was dated on or before the last day of the month in which the limitations were exceeded.

(iv) A member who receives benefits to which he or she is not entitled must repay those benefits to PERS.

(B) The member will reestablish active membership the first of the calendar month following the month in which the limitations were exceeded.

(C) The member's account must be rebuilt in accordance with the provisions of section (9) of this rule.

(b) If the member has been retired for less than six calendar months:

(A) PERS will cancel the member's retirement effective the date the member was reemployed.

(B) All retirement benefits received by the member must be repaid to PERS in a single payment.

(C) The member will reestablish active membership effective the date the member was reemployed.

(D) The member account will be rebuilt as of the date that PERS receives the single payment. The amount in the member account must be the same as the amount in the member account at the time of the member's retirement.

(8) For purposes of determining period(s) of employment in section (2) of this rule:

(a) Hours of employment are hours on and after the retired member's effective retirement date for which the member receives wages, salary, paid leave, or other compensation.

(b) Hours of employment that are performed under the provisions of section (4) of this rule on or after the later of January 1, 2004, or the operative date of the applicable statutory provision, are not counted.

(9) Reemployment under ORS 238.078(1). If a member has been retired for service for more than six calendar months and is reemployed in a qualifying position by a participating employer under the provisions of 238.078(1):

(a) PERS will cancel the member's retirement effective the date the member is reemployed.

(b) The member will reestablish active membership on the date the member is reemployed.

(c) If the member elected a benefit payment option other than a lump sum option under ORS 238.305(2) or (3), the last monthly service retirement allowance payment to which the member is entitled is for the month before the calendar month in which the member is reemployed. Upon subsequent retirement, the member may choose a different benefit payment option.

(A) The member's account will be rebuilt as required by ORS 238.078 effective the date active membership is reestablished.

(B) Amounts from the Benefits-In-Force Reserve (BIF) credited to the member's account under the provisions of paragraph (A) of this subsection will be credited with earnings at the BIF rate or the assumed rate, whichever is less, from the date of retirement to the date of active membership.

(d) If the member elected a partial lump sum option under ORS 238.305(2), the last monthly service retirement allowance payment to which the member is entitled is for the month before the calendar month in which the member is reemployed. The last lump sum or installment payment to which the member is entitled is the last payment due before the date the member is reemployed. Upon subsequent retirement, the member may not choose a different benefit payment option unless the member has repaid to PERS in a single payment an amount equal to the lump sum and installment benefits received and the earnings that would have accumulated on that amount.

(A) The member's account will be rebuilt as required by ORS 238.078 effective the date active membership is reestablished.

(B) Amounts from the BIF credited to the member's account under the provisions of paragraph (A) of this subsection, excluding any amounts attributable to repayment by the member, will be credited with earnings at the BIF rate or the assumed rate, whichever is less, from the date of retirement to the date of active membership.

(e) If the member elected the total lump sum option under ORS 238.305(3), the last lump sum or installment payment to which the member is entitled is the last payment due before the date the member is reemployed. Upon subsequent retirement, the member may not choose a different benefit payment option unless the member has repaid to PERS in a single payment an amount equal to the benefits received and the earnings that would have accumulated on that amount.

(A) If the member repays PERS as described in this subsection the member's account will be rebuilt as required by ORS 238.078 effective the date that PERS receives the single payment.

(B) If any amounts from the BIF are credited to the member's account under the provisions of paragraph (A) of this subsection, the amounts may not be credited with earnings for the period from the date of retirement to the date of active membership.

(f) If the member received a lump sum payment under ORS 238.315:

(A) If the payment was dated before the date the member is reemployed, the member is not required or permitted to repay the benefit amount. Upon subsequent retirement:

(i) The member may choose a different benefit payment option.

(ii) The member's retirement benefit will be calculated based on the member's periods of active membership after the member's initial effective retirement date.

(B) If the payment was dated on or after the date the member is reemployed, the member must repay the benefit amount. Upon subsequent retirement:

(i) The member may choose a different benefit payment option.

(ii) The member's retirement benefit will be calculated based on the member's periods of active membership before and after the member's initial effective retirement date.

(iii) The member's account will be rebuilt as described in ORS 238.078(2).

(g) A member who receives benefits to which he or she is not entitled must repay those benefits to PERS.

(10) Reemployment under ORS 238.078(2). If a member has been retired for less than six calendar months and is reemployed in a qualifying position by a participating employer under the provisions of 238.078(2):

(a) PERS will cancel the member's retirement effective the date the member is reemployed.

(b) All retirement benefits received by the member must be repaid to PERS in a single payment.

(c) The member will reestablish active membership effective the date the member is reemployed.

(d) The member account will be rebuilt as of the date that PERS receives the single payment. The amount in the member account must be the same as the amount in the member account at the time of the member's retirement.

(e) Upon subsequent retirement, the member may choose a different benefit payment option.

(11) Upon the subsequent retirement of any member who reestablished active membership under ORS 238.078 and this rule, the retirement benefit of the member must be calculated using the actuarial equivalency factors in effect on the effective date of the subsequent retirement.

(12) The provisions of paragraphs (9)(c)(B), (9)(d)(B), and (9)(e)(B) of this rule are applicable to retired members who reestablish active membership under ORS 238.078 and this rule and whose initial effective retirement date is on or after March 1, 2006.

(13) Reporting requirement. A participating employer that employs a retired member must notify PERS in a format acceptable to PERS under which statute the retired member is employed.

(a) Upon request by PERS, a participating employer must certify to PERS that a retired member has not exceeded the number of hours allowed under ORS 238.082 and section (2) of this rule.

(b) Upon request by PERS a participating employer must provide PERS with business and employment records to substantiate the actual number of hours a retired member was employed.

(c) Participating employers must provide information requested under this section within 30 days of the date of the request.

(14) Sick leave. Accumulated unused sick leave reported by an employer to PERS upon a member's retirement, as provided in ORS 238.350, may not be made available to a retired member returning to employment under sections (2) or (9) of this rule.

(15) Subsections (4)(c) and (4)(d) of this rule are repealed effective January 2, 2026.

(16) Subsection (4)(e) of this rule is repealed effective June 30, 2018.

Stat. Auth.: ORS 238.650

Stats. Implemented: ORS 238.078, 238.082, 238.088, 238.092, 399.075, 2007 OL Ch. 499 & 774, 2015 OL Ch. 108 & 475

Hist.: PERS 1-1994, f. 3-29-94, cert. ef. 4-1-94; PERS 1-1996, f. & cert. ef. 3-26-96, Renumbered from 459-010-0182; PERS 13-1998, f. & cert. ef. 12-17-98; PERS 7-2001, f. & cert. ef. 12-7-01; PERS 18-2003(Temp), f. & cert. ef. 12-15-03 thru 5-31-04; PERS 19-2004,

f. & cert. ef. 6-15-04; PERS 3-2006, f. & cert. ef. 3-1-06; PERS 18-2007, f. & cert. ef. 11-23-07; PERS 3-2009, f. & cert. ef. 4-6-09; PERS 11-2009, f. & cert. ef. 12-1-09; PERS 7-2012, f. & cert. ef. 3-28-12; PERS 5-2013, f. & cert. ef. 3-29-13; PERS 3-2014, f. & cert. ef. 1-31-14; PERS 7-2015, f. & cert. ef. 5-29-15; PERS 6-2016, f. 11-18-16, cert. ef. 1-1-17

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Oregon State Marine Board
Chapter 250

Rule Caption: Prohibited boating on the Deschutes River during Tetherow Road Bridge construction.
Adm. Order No.: OSMB 18-2016(Temp)
Filed with Sec. of State: 12-5-2016
Certified to be Effective: 12-5-16 thru 12-31-16
Notice Publication Date:
Rules Suspended: 250-020-0091(T)
Subject: This rule, as described, is no longer needed as construction has been completed. This rule prohibited boat operation on the Deschutes River near RM 141.1 in the area of the Tetherow Bridge due to scheduled construction removal and replacement of the bridge.
Rules Coordinator: June LeTarte—(503) 378-2617

250-020-0091
Boat Operations in Deschutes County

(1) Marine Toilets: No person shall maintain or operate upon the following-named inland waters of this state any boat which is equipped with a toilet unless such toilet has an approved device to render waste harmless, or unless such toilet is rendered inoperative by having the discharge outlet effectively seals. "An approved device" is a marine toilet, or marine toilet attachment, which has been approved by the State Board of Health and the State Sanitary Authority:

(a) Paulina Lake;
(b) East Lake;
(c) Elk Lake;
(d) Big Lava Lake;
(e) Wickiup Reservoir;
(f) Crane Prairie Reservoir;
(g) Big Cultus Lake;
(h) Little Cultus Lake.

(2) No person shall operate a motorboat in excess of 10 MPH on: Deschutes River and Davis Creek Arms of Wickiup Reservoir.

(3) No person shall operate a motorboat for any purpose on the following area: Torso Lake.

(4) No person shall operate a motorboat except with an electric motor on the following areas:

(a) Meadow Lake;
(b) Hosmer Lake.

(5) Deschutes River:

(a) No person shall operate a motorboat for the purpose of towing a person on water skis, surfboard or similar device and no person shall engage in waterskiing or similar activities on the Deschutes River;

(b) No person shall operate jet ski type boats on the Deschutes River. For the purposes of this rule, jet ski type boat means any motorized vessel or other description of watercraft which is generally less than ten feet in length and capable of exceeding a speed of 15 MPH, including but not limited to jetskis, wet bikes, and surf jets;

(c) No person shall operate a motorboat in excess of a "slow-no wake" speed limit between Wickiup Dam and the Deschutes National Forest Boundary in Sec. 14.T.18.S., R.11.E., W.M.;

(d) No person shall operate a motorboat between LaPine State Recreation area boat ramp and Pringle Falls;

(e) No person shall operate a motorboat between Aspen Camp boat ramp and the north end of Lava Island in Sec. 22.T.18.S.,R.11.E., W.M.

(f) No person shall operate a motorboat between the Deschutes National Forest boundary in Sec. 14.T.18.S.,R.11.E., W.M. and Mirror Pond Dam.

(g) No person shall operate a motorboat for any purpose between the Mirror Pond Dam and the Jefferson County Line.

(h) No person shall operate a boat in the area of the Tetherow Road Bridge located near river mile 141.1 on the Deschutes River due to the destruction and replacement of the bridge.

(A) Boaters are required to exit the river, as directed by posted signs and in-water buoys, upstream of the bridge at the Tetherow Crossing Park and portage around the bridge area.

(B) As directed by posted signs, boaters may re-enter the river downstream of the bridge on Deschutes County Property.

(C) Boater restrictions on the Deschutes River, as described in 250-020-0091(5)(h) are in effect from:

(i) 11:59 pm, August 21, 2016 to 11:59 pm, August 24, 2016, and
(ii) 11:59 pm, October 3, 2016 to 11:59 pm, October 6, 2016.

Stat. Auth.: ORS 830.110 & 830.175
Stats. Implemented: ORS 830.110 & 830.175
Hist.: MB 26, f. 7-20-64; MB 52, f. 8-17-73, ef. 9-1-73; MB 57, f. 7-2-74, ef. 7-2-74(Temp) & 7-25-74(Perm), Renumbered from 250-020-0170; MB 10-1988, f. & cert. ef. 6-28-88; MB 13-1988, f. 12-28-88, cert. ef. 1-1-89; MB 5-1993, f. & cert. ef. 7-14-93; MB 12-1996, f. & cert. ef. 12-4-96; MB 7-1997, f. & cert. ef. 7-17-97; OSMB 11-1998(Temp), f. & cert. ef. 7-15-98 thru 12-31-98; Administrative correction 8-5-99; OSMB 4-2015, f. 4-30-15, cert. ef. 5-1-15; OSMB 10-2015(Temp), f. & cert. ef. 10-19-15 thru 12-31-15; Administrative correction, 1-22-16; OSMB 11-2016(Temp), f. 8-11-16, cert. ef. 8-21-16 thru 12-31-16; OSMB 12-2016(Temp), f. 8-18-16, cert. ef. 8-21-16 thru 12-31-16; OSMB 13-2016(Temp), f. & cert. ef. 9-23-16 thru 12-31-16; Temporary Suspended by OSMB 18-2016(Temp), f. & cert. ef. 12-5-16 thru 12-31-16

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Rule Caption: Closure of boat access on Deschutes River in the area of Bend Whitewater Park
Adm. Order No.: OSMB 19-2016(Temp)
Filed with Sec. of State: 12-5-2016
Certified to be Effective: 12-5-16 thru 3-15-17
Notice Publication Date:
Rules Amended: 250-020-0091
Subject: This rule action will prevent boat operation on the Deschutes River in the area of the Bend Whitewater Park and the Colorado Street Bridge, approximate River Mile 167.6, due to scheduled maintenance construction.
Rules Coordinator: June LeTarte—(503) 378-2617

250-020-0091
Boat Operations in Deschutes County

(1) Marine Toilets: No person shall maintain or operate upon the following-named inland waters of this state any boat which is equipped with a toilet unless such toilet has an approved device to render waste harmless, or unless such toilet is rendered inoperative by having the discharge outlet effectively seals. "An approved device" is a marine toilet, or marine toilet attachment, which has been approved by the State Board of Health and the State Sanitary Authority:

(a) Paulina Lake;
(b) East Lake;
(c) Elk Lake;
(d) Big Lava Lake;
(e) Wickiup Reservoir;
(f) Crane Prairie Reservoir;
(g) Big Cultus Lake;
(h) Little Cultus Lake.

(2) No person shall operate a motorboat in excess of 10 MPH on: Deschutes River and Davis Creek Arms of Wickiup Reservoir.

(3) No person shall operate a motorboat for any purpose on the following area: Torso Lake.

(4) No person shall operate a motorboat except with an electric motor on the following areas:

(a) Meadow Lake;
(b) Hosmer Lake.

(5) Deschutes River:

(a) No person shall operate a motorboat for the purpose of towing a person on water skis, surfboard or similar device and no person shall engage in waterskiing or similar activities on the Deschutes River;

(b) No person shall operate jet ski type boats on the Deschutes River. For the purposes of this rule, jet ski type boat means any motorized vessel or other description of watercraft which is generally less than ten feet in length and capable of exceeding a speed of 15 MPH, including but not limited to jetskis, wet bikes, and surf jets;

(c) No person shall operate a motorboat in excess of a "slow-no wake" speed limit between Wickiup Dam and the Deschutes National Forest Boundary in Sec. 14.T.18.S., R.11.E., W.M.;

(d) No person shall operate a motorboat between LaPine State Recreation area boat ramp and Pringle Falls;

(e) No person shall operate a motorboat between Aspen Camp boat ramp and the north end of Lava Island in Sec. 22.T.18.S.,R.11.E., W.M.

(f) No person shall operate a motorboat between the Deschutes National Forest boundary in Sec. 14.T.18.S.,R.11.E., W.M. and Mirror Pond Dam.

(g) No person shall operate a motorboat for any purpose between the Mirror Pond Dam and the Jefferson County Line.

(h) No person shall operate a boat on the Deschutes River in the area of the Colorado Avenue Bridge, approximate River Mile 167.6, due to scheduled construction maintenance.

(A) Boaters are required to exit the river at the designated takeout, as posted, and portage around the bridge area. Boaters may re-enter the river downstream at Miller's Landing Park, approximate River Mile 167.4.

(B) Boater access restriction on the Deschutes River, as described in 250-020-0091(5)(h) is in effect from December 5, 2016 to 11:59 pm, March 15, 2017.

Stat. Auth.: ORS 830.110 & 830.175
Stats. Implemented: ORS 830.110 & 830.175
Hist.: MB 26, f. 7-20-64; MB 52, f. 8-17-73, ef. 9-1-73; MB 57, f. 7-2-74, ef. 7-2-74(Temp) & 7-25-74(Perm), Renumbered from 250-020-0170; MB 10-1988, f. & cert. ef. 6-28-88; MB 13-1988, f. 12-28-88, cert. ef. 1-1-89; MB 5-1993, f. & cert. ef. 7-14-93; MB 12-1996, f. & cert. ef. 12-4-96; MB 7-1997, f. & cert. ef. 7-17-97; OSMB 11-1998(Temp), f. & cert. ef. 7-15-98 thru 12-31-98; Administrative correction 8-5-99; OSMB 4-2015, f. 4-30-15, cert. ef. 5-1-15; OSMB 10-2015(Temp), f. & cert. ef. 10-19-15 thru 12-31-15; Administrative correction, 1-22-16; OSMB 11-2016(Temp), f. 8-11-16, cert. ef. 8-21-16 thru 12-31-16; OSMB 12-2016(Temp), f. 8-18-16, cert. ef. 8-21-16 thru 12-31-16; OSMB 13-2016(Temp), f. & cert. ef. 9-23-16 thru 12-31-16; Temporary Suspended by OSMB 18-2016(Temp), f. & cert. ef. 12-5-16 thru 12-31-16; OSMB 19-2016(Temp), f. & cert. ef. 12-5-16 thru 3-15-17

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Oregon Youth Authority
Chapter 416

Rule Caption: Amending the date and content of the BRS Rate Table to reflect new rates.
Adm. Order No.: OYA 10-2016
Filed with Sec. of State: 12-8-2016
Certified to be Effective: 12-8-16
Notice Publication Date: 12-1-2016
Rules Amended: 416-335-0090
Subject: OYA is amending the date and content of the BRS Rate Table referenced in OAR 416-335-0090 to reflect new rates.
Rules Coordinator: Winifred Skinner—(503) 373-7570

416-335-0090
Billing and Payment for Services and Placement Related Activities

(1) Billable Care Days:

(a) The BRS Contractor is compensated for a Billable Care Day (Service and Placement Related Activities rates) on a fee-for-service basis in accordance with OAR 410-170-0110 and this rule.

(b) The BRS Contractor may include overnight Transitional Visits by the BRS Client to another placement in its Billable Care Days. The BRS Contractor must:

(A) Receive prior approval for the Transitional Visit from OYA;

(B) Ensure that the Transitional Visit is in support of the MSP, MSP-T, or MSP-S goals related to transition;

(C) Pay the hosting placement at the established Absent Rate for the sending BRS Provider; and

(D) Ensure that the hosting placement will not seek any reimbursement from OYA for the care of the visiting BRS Client.

(2) Absent Days:

(a) The BRS Contractor is compensated for an Absent Day at the Absent Day rate in order to hold a BRS Program placement for a BRS Client with the prior approval of the BRS Client's JPPO and the Community Resources Manager.

(b) Notwithstanding OAR 410-170-0110(4), the BRS Contractor may request prior approval from OYA to be reimbursed for more than eight calendar days of home visits in a month for a BRS Client. However, any additional days of home visits approved under this rule will be paid at the Absent Day rate.

(3) The BRS Contractor may be reimbursed only for the BRS Type of Care authorized in the contract with OYA.

(4) Invoice Form:

(a) The BRS Contractor must submit a monthly billing form to OYA in a format acceptable to the Agency, on or after the first day of the month following the month in which it provided Services and Placement Related Activities to the BRS Client. The billing form must specify the number of Billable Care Days and Absent Days for each BRS Client in that month.

(b) The BRS Contractor must provide upon request, in a format that meets OYA's approval, written documentation of each BRS Client's location for each day claimed as a Billable Care Day and an Absent Day.

(c) The BRS Contractor may only submit a claim for a Billable Care Day and an Absent Day consistent with the Agency's prior authorization or approval.

(5) Billable Care Day and Absent Day rates are provided in the "BRS Rates Table", dated May 1, 2016, which is adopted as Exhibit 1 and incorporated by reference into this rule. A printed copy may be obtained from OYA.

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.010, 420A.014
Hist.: OYA 3-2013, f. 11-15-13, cert. ef. 1-1-14; OYA 2-2016(Temp), f. & cert. ef. 3-10-16 thru 6-10-16; OYA 4-2016, f. & cert. ef. 5-2-16; OYA 5-2016(Temp), f. & cert. ef. 6-3-16 thru 11-29-16; OYA 10-2016, f. & cert. ef. 12-8-16

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Psychiatric Security Review Board
Chapter 859

Rule Caption: This change will correct a citation error from an earlier version of OAR 859-010-0005(11).
Adm. Order No.: PSRB 9-2016
Filed with Sec. of State: 11-18-2016
Certified to be Effective: 11-18-16
Notice Publication Date: 12-1-2015
Rules Amended: 859-010-0005
Subject: This amended rule will make no substantive changes. When submitted originally, subsection (c) of section (11) was left in subsection (b) accidentally, as though it were a part of subsection (b), rather than the next subsection. This change will move subsection (11)(c) to its own paragraph.
Rules Coordinator: Sid Moore—(503) 229-5596

859-010-0005
Definitions

(1) "Abscond" means a client on conditional release has departed without permission from the case manager or Board and the client's whereabouts are unknown.

(2) "Administrative Hearing" means a meeting of the Board where a quorum is present and a matter is reviewed (e.g. an outpatient supervisor request for modification to a client's conditional release plan). The Board shall consider information in the written record only and no oral testimony shall be received; If an objection is made to the administrative hearing, the client or the state has the right to request a full hearing. On its own motion, the Board may require further information, testimony or the presence of the client and therefore, set the matter for a full hearing.

(3) "Administrative Meeting" is any meeting of the Board where a quorum is present for the purpose of considering matters relating to Board policy and administration. Minutes shall be taken during an administrative meeting and distributed to Board members and interested persons. Minutes shall be voted on and approved at subsequent administrative meetings;

(4) "Case Managers" are individuals designated in the conditional release order who are responsible for ensuring clients on conditional release receive the services and support they need and reporting to the PSRB a client's progress, activities and compliance with conditions of release or lack thereof.

(5) "Client" refers to any person under the jurisdiction of the Board and may be used interchangeably with person or patient or outpatient.

(6) "Conditional Release" is a grant by the court or the Board for a client, patient or defendant to reside outside a state hospital in the community under conditions mandated by the court or Board for monitoring and treatment of mental and physical health.

(7) "Danger"; "Substantial Danger"; or "Dangerousness" means a demonstration or previous demonstration of intentional, knowing, reckless or criminally negligent behavior which places others at risk of physical injury because of the person's mental disease or defect.

(8) "Escape" means:

(a) A client committed to a state hospital:

(A) Leaves the supervision of hospital staff without permission;

(B) Leaves the hospital without permission; or

(C) Fails to return at the appointed time to the hospital.

(b) Any client who leaves the State of Oregon without authorization of the Board;

(c) Any client who fails to return to the State of Oregon as directed by the Board.

(9) "Full Hearing" is a meeting of the Board where parties are present, testimony is taken and written findings on the issue(s) before the Board are made.

(10) "Insanity Defense", also known as "GEI", refers to a plea or finding of "Guilty Except for Insanity". Nomenclature. For offenses committed on or after January 1, 1984, a person is guilty except for insanity if, as a result of a mental disease or defect at the time of engaging in criminal con-

duct, the person lacked substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law. The name of the insanity defense from January 1, 1978, through December 31, 1983, was "not responsible due to mental disease or defect." From January 1, 1971, through December 31, 1977, the insanity defense was known as "not guilty by reason of mental disease or defect." The name of the insanity defense prior to 1971 was "not guilty by reason of insanity."

(11) "Mental Disease or Defect"

(a) "Mental Defect" is defined as mental retardation, traumatic brain injury, brain damage or other biological dysfunction that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning and is defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM 5) of the American Psychiatric Association.

(b) "Mental Disease" is defined as any diagnosis of a psychiatric condition which is a significant behavioral or psychological syndrome or pattern that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning and is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) of the American Psychiatric Association.

(c) "Qualifying Mental Disease or Defect" or "Mental Disease or Defect" is defined as a mental disease or mental defect described in subsections (a) and (b), excluding those conditions described in subsection (d). A qualifying mental disease or defect includes:

(A) A mental disease or mental defect in a state of remission which could with reasonable medical probability occasionally become active; or

(B) A mental disease or mental defect that could become active as a result of a non-qualifying mental disease or defect.

(d) *"Non-Qualifying Mental Disease or Defect" is defined as a mental disease or defect where the condition is:

(A) A diagnosis solely constituting the ingestion of substances (e.g., chemicals or alcohol), including but not limited to alcohol-induced psychosis;

(B) An abnormality manifested solely by repeated criminal or otherwise antisocial conduct; or

(C) An abnormality constituting a personality disorder.

(12) "Party" means the State, which includes the Oregon Department of Justice or, if representing the State's interest, the District Attorney from the county where the GEI was adjudicated, client and client's counsel.

(13) "PSRB" or "Board" means the Oregon Psychiatric Security Review Board.

(14) "Quorum" means the presence of at least three members, in person or on the telephone, of the Adult Panel of the Board.

(15) "SHRP" means the State Hospital Review Panel. It is an entity established by OHA that supervises Tier Two GEI patients while they reside at the state hospital.

(16) "State Hospital" means any state institution or facility operated by the Oregon Health Authority.

(17) "Tier One or Tier Two Offender" means an individual adjudicated guilty except for insanity of a crime as defined in ORS 161.332.

(18) "Victim" means the person or persons who have suffered financial, social, psychological or physical harm as a result of a crime that brought the client under the Board's jurisdiction. In the case of a homicide or abuse of a corpse, a member of the immediate family of the decedent and, in the case of a minor victim, the legal guardian of the minor. In no event shall the PSRB client be considered a victim of his/her own GEI case.

Stat. Auth.: ORS 161.387

Stats. Implemented: ORS 161.295 - 161.400

Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85; PSRB 1-1987, f. & ef. 2-4-87; PSRB 1-1995, f. & cert. ef. 1-11-95; PSRB 2-2014, f. & cert. ef. 12-18-14; PSRB 2-2015(Temp), f. & cert. ef. 12-3-15 thru 5-29-16; Administrative correction, 6-21-16; PSRB 8-2016, f. & cert. ef. 10-5-16; PSRB 9-2016, f. & cert. ef. 11-18-16

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Rule Caption: Incorporates "DSM 5" by reference, replacing "DSM IV-TR" for "mental disease or defect" diagnoses.

Adm. Order No.: PSRB 10-2016

Filed with Sec. of State: 12-13-2016

Certified to be Effective: 12-13-16

Notice Publication Date: 12-1-2015

Rules Amended: 859-510-0005

Subject: OAR 859-510-0005 defines terms relevant and applicable to the Psychiatric Security Review Board's Juvenile Panel, including definitions of "mental disease or defect." Section 11 of the rule contains two references to a diagnostic tool—the Diagnostic and Statistical Manual of Mental Disorders IV, text revision (DSM IV-TR)—which the Oregon State Hospital ceased using in October 2015 in favor of the DSM 5. The broader treatment community is also either using the DSM 5 or is in the process of transitioning to it. This rule modification incorporates the DSM 5 by reference, reflecting the treatment community's change from the DSM IV-TR.

Rules Coordinator: Sid Moore—(503) 229-5032

859-510-0005

Definitions

(1) "Administrative Hearing" means a meeting of the Board at which a quorum is present but the youth is not for the purpose of deliberating about a youth's status or conditional release plan based upon the written record before the Board.

(2) "Administrative Meeting" means any meeting of the Board at which a quorum is present for the purpose of considering matters relating to Board policy and administration, at which minutes are taken, and approved at a subsequent administrative meeting by a majority of members present.

(3) "Board" means the juvenile panel of Oregon Psychiatric Security Review Board as constituted under ORS 161.385.

(4) "Burden of proof" means the responsibility of the youth or the state to convince the Board of the truth of its version or interpretation of facts or issues in dispute.

(5) "Commit" means order of placement in a secure facility.

(6) "Conditional Release" means an order by the court or Board authorizing a youth to reside outside a Secure Adolescent In-patient Program (SAIP), Secure Children's In-patient Program (SCIP), or Intensive Treatment Services (ITS), in the community under conditions established for the monitoring and treatment of the youth's mental and physical health.

(7) "Department of Human Services" and "Department" mean the Oregon Department of Human Services as constituted under ORS 409.010.

(8) "Discharge" means the termination of a youth's jurisdiction under the Board because the youth is either no longer affected by a serious mental condition or no longer affected by a mental disease or defect that presents a substantial danger to others and requires regular medical care, medication, supervision or treatment; or term of jurisdiction has lapsed.

(9) "Full Hearing" means a meeting of the Board at which a quorum is present, the youth is present, evidence is received, a youth's status is reviewed pursuant to Chapter 419C and at the conclusion of which the Board makes findings of fact and conclusions of law as required by law from which written orders will issue.

(10) "Mental Defect" means that which is manifested by mental retardation or developmental disability if a mental deficiency exists concurrently with qualitative deficits in activities of daily living and is not otherwise attributable to mental illness or substance abuse or influenced by current situational trauma.

(11) "Mental Disease" is defined as any diagnosis of mental disorder which is a significant behavioral or psychological syndrome or pattern that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning and is defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM 5) of the American Psychiatric Association

(12) The term "mental disease or defect" does not include an abnormality manifested solely by repeated criminal or otherwise antisocial conduct; nor constituting solely a conduct or a personality disorder; nor solely an alcohol or drug abuse or dependence diagnosis.

(13) "Mental status" is defined as the mental, emotional, and behavioral functioning of a youth.

(14) "Patient" means any youth under the jurisdiction of the JPSRB, residing in a SAIP or SCIP.

(15) "Proof" means the achievement of a designated legal standard for persuading the trier of fact that a proposition is true. The standard of proof on all issues at hearings of the Board is by the preponderance of the evidence.

(16) "Quorum" means the presence at a hearing or meeting of at least three members of the Board.

(17) "Reasonable medical probability" means the finding by a physician or other qualified health professional that a given condition or illness is more likely than not to exist.

(18) "Responsible Except for Insanity" means the affirmative defense one must successfully assert in order to be placed under the jurisdiction of the JPSRB; or a finding by a judge that a youth, as a result of a mental disease or defect at the time the youth committed the act(s) alleged in the petition, lacked substantial capacity either to appreciate the nature and quality of the act or to conform the youth's conduct to the requirements of law.

(19) "Revocation" means the return to a secure residential adolescent or children's treatment facility of a youth pursuant to an order of the Board when the youth has violated the terms of a conditional release order or has experienced a change in mental status giving reasonable cause to believe that the youth may present a danger to others and cannot be controlled by appropriate interventions.

(20) "SAIP" means secure adolescent in-patient treatment program designated by the Oregon Health Authority.

(21) "SCIP" means secure child in-patient treatment program designated by the Oregon Health Authority.

(22) "SITP" means a secure child and adolescent Seniors and People with Disabilities (SPD) in-patient treatment program designated by Department of Human Services.

(23) "Secure" means that the doors to the facility are locked at all times. Ingress and egress are controlled by staff.

(24) "Secure In-patient Program Pass", means any time a youth is authorized to be away from a secure child or adolescent facility's grounds for any length of time unaccompanied by facility staff.

(25) "Serious mental condition" is one of the three specifically delineated diagnoses listed in 419C.520(3).

(26) "Substantial danger" means the level of danger exhibited by threats of or engagement in acts of intentional, knowing, reckless or negligent behavior which places another person at risk of physical injury.

Stat. Auth.: ORS 161.387, OL 2007, Ch. 889 § 6 (SB 328)
Stats. Implemented: ORS 161.295 - 161.400, 419C.411(2), 419C.520 - 419C.544
Hist.: PSRB 2-2010, f. & cert. ef. 9-28-10; PSRB 10-2016, f. & cert. ef. 12-13-16

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Public Utility Commission
Chapter 860

Rule Caption: Creating a New Division for Oregon Universal Service Fund (OUSF) Rules.
Adm. Order No.: PUC 5-2016
Filed with Sec. of State: 11-22-2016
Certified to be Effective: 11-22-16
Notice Publication Date: 10-1-2016
Rules Adopted: 860-100-0001, 860-100-0005
Rules Renumbered: 860-032-0640 to 860-100-0130, 860-032-0650 to 860-100-0140, 860-032-0660 to 860-100-0150, 860-032-0670 to 860-100-0160
Rules Ren. & Amend: 860-032-0610 to 860-100-0100, 860-032-0620 to 860-100-0110, 860-032-0630 to 860-100-0120
Subject: These rule changes move the rules relating to the Oregon Universal Service Fund (OUSF) from Division 032 to a new Division 100 as the first step in creating a comprehensive framework in a separate division.
Rules Coordinator: Diane Davis—(503) 378-4372

860-100-0001
Scope and Applicability

(1) The rules in this Division apply to all telecommunications providers as defined in 860-100-0005 (11).

(2) Upon request or its own motion, the Commission may waive any of the division 100 rules for good cause shown. A request for waiver must be made in writing, unless otherwise allowed by the Commission.

Stat. Auth.: ORS Ch. 183, 192, 756, 759
Stats. Implemented: ORS 756.040, 759.005, 759.020
Hist.: PUC 5-2016, f. & cert. ef. 11-22-16

860-100-0005
Definitions for the Oregon Universal Service Fund

For the purpose of this Division:

(1) "Certificate of Authority" means a certificate of authority to provide intrastate telecommunications service on a for-hire basis that may be issued by the Commission under ORS 759.020.

(2) "Competitive provider" means a competitive telecommunications provider as defined in ORS 759.005(1), who provides services authorized pursuant to ORS 759.020.

(3) "Cooperative" means a cooperative corporation or association, which provides local exchange telecommunications service within its own exchanges, which is organized under ORS Chapter 62, and which is certified under ORS 759.025(2).

(4) "Local exchange service" means local exchange telecommunications service as defined in ORS 759.005(3). Local exchange service includes "shared service."

(5) "OUSF Board" means the advisory board selected by the Commission to provide advice on the administration of the OUS Fund.

(6) "OUS Administrator" means the person selected by the Commission to administer the OUS Fund.

(7) "OUS Fund" means the Oregon Universal Service Fund.

(8) "Pay telephone" means a telephone instrument, generally placed in public areas, for transient use on a pay-per-call basis. "Pay telephone" instruments may be coin operated, noncoin operated, prepay, postpay, central office controlled, instrument controlled, provided by local exchange carriers, or provided by other persons or entities.

(9) "Private telecommunications network" means a system, including the construction, maintenance, or operation of the system, for the provision of a service or any portion of a service, by a person for the exclusive use of that person and not for resale, directly or indirectly. "Private telecommunications network" includes services provided by the State of Oregon pursuant to ORS 190.240 and 283.140.

(10) "Shared service" means shared telecommunications service as defined in ORS 759.005(6) and:

(a) The provision of telecommunications and information management services and equipment:

(A) To a user group comprised of one person or association served by a single telecommunications system;

(B) Located in a single building or in several buildings on contiguous property;

(C) By a commercial shared service provider or by a users' association;

(D) Through privately owned customer premises equipment and associated data processing and information management services; and

(b) Includes connection to local exchange service.

(11) "Telecommunications provider" or "provider" includes competitive providers, cooperatives, and telecommunications utilities.

(12) "Telecommunications service" or "service" means two-way switched access and transport of voice communications, and all services provided in connection with such services, but excludes:

(a) Services provided by radio common carrier;

(b) One-way transmission of television signals;

(c) Surveying;

(d) Private telecommunications networks; and

(e) Customer communications that take place on the customer's side of the network interface.

(13) "Telecommunications utility" means a person who is not a competitive provider and is designated as a telecommunications utility under OAR 860-032-0010.

Stat. Auth.: ORS Ch. 183, 192, 756, 759
Stats. Implemented: ORS 756.040, 759.005, 759.020
Hist.: PUC 5-2016, f. & cert. ef. 11-22-16

860-100-0100
General Provisions

(1) For the purpose of these rules, each calendar year has four quarters as follows: January 1 through March 31; April 1 through June 30; July 1 through September 30; and October 1 through December 31.

(2) For the purpose of OAR 860-100-0100 through 860-100-0150, the quarterly revenue worksheet identified as "OPUC OUS 2" is known as the "contribution report."

(3) A telecommunications provider may pay any amounts due to the Public Utility Commission (Commission) by electronic transfer.

(4) The Commission may add all costs incurred in collecting a past-due "Oregon universal service" (OUS) contribution amount. In the event the Commission refers the debt to the Department of Revenue or to a collection agency, the Commission may add to the debt the anticipated amount necessary to generate a net return to the Commission of the amount of the debt.

(5) A telecommunications provider must pay a service fee in accordance with OAR 860-001-0050 for each payment returned for non-sufficient funds.

(6) In addition to any other penalty, obligation or remedy provided by law, the Commission may suspend or cancel the telecommunications provider's certificate of authority to provide telecommunications service in Oregon for its failure to file its contribution report or its failure to pay its contribution amount in full.

(7) Except as otherwise provided by law, if after an audit or review the Commission determines that the telecommunications provider has overpaid its OUS contribution amount, the Commission will provide the telecommunications provider a credit in that amount against sums subsequently due from the telecommunications provider.

(8) In computing any time prescribed or allowed by these rules, the day of the act or event from which the designated time begins to run may not be included. The last day of the time period must be included, unless it is a Saturday or legal holiday, including Sunday, in which event the period runs until the end of the next day that is not a Saturday or a legal holiday. Legal holidays are those identified in ORS 187.010 and 187.020.

Stat. Auth.: ORS 183, 192, 756 & 759
Stats. Implemented: ORS 756.040, 759.015 & 759.425
Hist.: PUC 23-2002, f. & cert. ef. 12-9-02; PUC 18-2004, f. & cert. ef. 12-30-04; Renumbered from 860-032-0610, PUC 5-2016, f. & cert. ef. 11-22-16

860-100-0110
Quarterly OUS Report: Filing and Payment

(1) For the purpose of the OUS fund, a telecommunications provider must file its contribution report with the OUS Administrator. For the first quarter (January through March) the contribution report is due on or before May 28, for the second quarter (April through June) it is due on or before August 28, for the third quarter (July through September) it is due on or before November 28, and for the fourth quarter (October through December) it is due on or before February 28 of the following year. The contribution report must include the signature of an officer of the telecommunications provider, or an officer's designee, verifying the accuracy of the information in the contribution report. In the case of the electronic filing, the required signature is an electronic signature. A telecommunications provider must send or transmit its contribution report so that it is received in the OUS Administrator's offices no later than 5 p.m. on the date it is due.

(2) A telecommunications provider must file the contribution report for each quarter with no exceptions, including when the contribution amount shown on the report is $0.00.

(3) The amount shown on the contribution report referenced in section (1) of this rule is due and payable by the telecommunications provider on or before the following days: February 28, May 28, August 28, and November 28. A telecommunications provider must send payment (electronically or by mail) so that it is received in the Commission's offices by no later than 5 p.m. on the date it is due.

(4) If the telecommunications provider's contribution amount for a quarter is less than a minimum of $10 (i.e., $9.99 or less), the telecommunications provider is not required to pay the contribution amount for that quarter but it must still file its contribution report. If the telecommunications provider has outstanding amounts owing for contributions, late statement fees, late payment penalties, and interest totaling more than the $10 minimum amount, this section does not apply and the total amount is due and payable.

(5) If a telecommunications provider fails to file a contribution report as required by these rules, the Commission shall impose a late report fee of $100.

(6) If a telecommunications provider files a contribution report but fails to pay the contribution amount in full on or before the day it is due, the Commission shall add a late payment fee equal to nine percent (9%) of the unpaid amount of the contribution, up to a maximum of $500.

(7) If a telecommunications provider fails to pay the contribution amount in full on or before the day it is due, the Commission shall add interest on the unpaid contribution amount at the rate of nine percent per annum from the day payment was due until paid.

(8) If the amount shown due on a contribution report is not paid on the due date, the Commission may issue a written notice of proposed assessment or proposed order to set the sum due. The Commission may waive the late report fee, the late payment fee, the interest on the unpaid contribution amount, or any combination thereof, if the provider requests the waiver and provides evidence showing that the provider paid its contribution amount late due to circumstances beyond its control.

(9) A telecommunications provider must submit revisions to a previously-filed contribution report no later than three years from its due date. If making the refunds arising from one or more Commission-verified revised contribution reports received from the telecommunications provider would have a material financial impact on the OUS fund, the OUSF Board may enter into an agreement with the telecommunications provider to spread payment of the refunds over a time period not to exceed three years.

Stat. Auth.: ORS 183, 192, 756 & 759
Stats. Implemented: ORS 756.040, 759.015 & 759.425
Hist.: PUC 23-2002, f. & cert. ef. 12-9-02; PUC 3-2009, f. & cert. ef. 4-14-09; PUC 4-2010, f. & cert. ef. 9-10-10; Renumbered from 860-032-0620, PUC 5-2016, f. & cert. ef. 11-22-16

860-100-0120
Estimated Report

(1) For any quarter for which a telecommunications provider fails to file a contribution report as required by these rules, the Commission may make a proposed contribution assessment based upon any information available to the Commission.

(2) The proposed assessment shall include a late payment fee equal to 9 percent of the proposed assessment amount, up to a maximum of $500 for that quarter.

(3) Each proposed assessment shall bear interest on the amount proposed at the rate of 9 percent per annum from the day the contribution amount was originally due.

(4) The Commission's proposed assessment for a non-filed contribution report must be made no later than three years after the contribution report's due date.

(5) Notwithstanding section (4) of this rule, if the telecommunications provider did not hold a certificate of authority, the Commission shall have an unlimited time to propose an assessment for the time period represented by the non-filed contribution report. The proposed assessment shall include all late payment fees and interest as specified in this rule.

(6) Prior to the expiration of the period allowed for filing a petition for a hearing, the telecommunications provider may file its contribution report. The Commission shall accept the report and calculate late report fees, late payment fees, and interest in accordance with the original due date for that quarter's contribution report and payment, if any, accompanying the report.

Stat. Auth.: ORS 183, 192, 756 & 759
Stats. Implemented: ORS 756.040, 759.015 & 759.425
Hist.: PUC 23-2002, f. & cert. ef. 12-9-02; Renumbered from 860-032-0630, PUC 5-2016, f. & cert. ef. 11-22-16

860-100-0130
Commission Audit and Proposed Assessment

(1) For any quarter for which a telecommunications provider's contribution report was due, the Commission may audit the telecommunications provider as the Commission deems necessary and practicable.

(2) The Commission's audit must be commenced no later than three years after the quarter's contribution report's due date. After completion of its audit, the Commission may propose to assess an additional contribution amount due from the telecommunications provider.

(3) In the event the telecommunications provider failed to file a contribution report for the quarter, the Commission shall add to the proposed assessment a late payment fee equal to 9 percent of the amount of the proposed assessment, up to a maximum amount of $500.

(4) Each proposed assessment shall bear interest on the additional amount proposed at the rate of 9 percent per annum from the day the original contribution amount was due.

(5) Notwithstanding section (2) of this rule, if the telecommunications provider did not hold a certificate of authority, the Commission shall have an unlimited time to audit the telecommunications provider for universal service charges.

Stat. Auth.: ORS 183, 192, 756 & 759
Stats. Implemented: ORS 756.040, 759.015 & 759.425
Hist.: PUC 23-2002, f. & cert. ef. 12-9-02; Renumbered from 860-032-0640, PUC 5-2016, f. & cert. ef. 11-22-16

860-100-0140
Notice and Hearing on Proposed Orders and Assessments

(1) The Commission shall provide written notice of the proposed order or proposed assessment to the telecommunications provider and allow the telecommunications provider an opportunity to request a hearing before the Commission.

(2) Within 30 days after service of the notice of proposed order or proposed assessment, a telecommunications provider may petition the Commission in writing for a hearing. If a petition is not filed within the 30-day period, the Commission shall enter a final order or assessment based upon information in the Commission's files. If a petition is filed within the 30-day period, the Commission shall grant the telecommunications provider a hearing and give the telecommunications provider at least 10 days' notice of the time and place of the hearing.

(3) The telecommunications provider must specify in its petition all reasons it disputes the proposed order or the proposed assessment. The Commission shall conduct a hearing on the telecommunications provider's petition under its rules governing hearings and proceedings. Unless the telecommunications provider has filed an amended contribution report, the amount shown on the contribution report shall not be subject to challenge by the telecommunications provider.

(4) A Commission order deciding the petition shall become final after service of the Commission's order upon the petitioning telecommunications provider.

(5) A proposed assessment made by the Commission under these rules is due and payable on the 10th day after the Commission's order becomes final.

Stat. Auth.: ORS 183, 192, 756 & 759
Stats. Implemented: ORS 756.040, 759.015 & 759.425
Hist.: PUC 23-2002, f. & cert. ef. 12-9-02; Renumbered from 860-032-0650, PUC 5-2016, f. & cert. ef. 11-22-16

860-100-0150
OUS Record-keeping Requirements

(1) A telecommunications provider shall produce for inspection or audit upon request of the Commission or its authorized representative all records supporting its contribution reports. The Commission, or its representative, shall allow the telecommunications provider a reasonable time to produce the records for inspection or audit.

(2) A telecommunications provider must keep all records supporting each contribution report for three years, or until a Commission review or audit is complete, whichever is later.

(3) In addition to any other penalty allowed by law, the Commission may suspend or cancel a telecommunications provider's certificate of authority to provide telecommunications service for its failure to produce for inspection or audit the records required by this rule.

Stat. Auth.: ORS 183, 192, 756 & 759
Stats. Implemented: ORS 756.040, 759.015 & 759.425
Hist.: PUC 23-2002, f. & cert. ef. 12-9-02; Renumbered from 860-032-0660, PUC 5-2016, f. & cert. ef. 11-22-16

860-100-0160
Refund of Oregon Universal Service Surcharge

(1) A Pay Telephone provider may apply for a refund of the Oregon Universal Service (OUS) surcharge imposed on, and paid by, the provider under ORS 759.425(4) for the provision of Pay Telephone service.

(2) An application for a refund of the OUS surcharge under this rule shall be on forms prescribed by the Public Utility Commission.

(a) An application shall contain the applicant's:

(A) Name;

(B) Address;

(C) Telephone number;

(D) Time period for which the application is made;

(E) Name of Pay Telephone provider;

(F) Contact person;

(G) Requested refund;

(H) Number of Pay Telephones located in Oregon;

(I) Signature of responsible party;

(J) Affidavit of charges and payment; and

(K) Mailing address for refund.

(b) The Pay Telephone provider shall be responsible for contacting the Commission to obtain an application form. Forms are available on the Commission's website or by contacting the Commission by telephone.

(3) Applications shall be made on a quarterly basis. Applications must be received by the Commission no later than 180 days after the end of each time period for which a refund is claimed. The quarterly time periods are July 1 through September 30, October 1 through December 31, January 1 through March 31, and April 1 through June 30. The initial period begins July 1, 2003, and ends September 30, 2003.

(a) For good cause shown, the Commission may allow a pay telephone provider to submit its application for refund beyond the 180-day deadline.

(b) Applications for service rendered and payments made prior to July 1, 2003, will not be considered.

(4) A Pay Telephone provider shall produce for inspection or audit upon request of the Commission, or its authorized representative, all records supporting its application for refund. The Commission, or its authorized representative, shall allow the Pay Telephone provider a reasonable time to produce the records for inspection or audit. A Pay Telephone provider must keep all records supporting each refund application for three years, or until a Commission review or audit is complete, whichever is later.

Stat. Auth.: ORS 183, 192, 756 & 759
Stats. Implemented: ORS 759.425(8)
Hist.: PUC 7-2003, f. & cert. ef. 4-28-03; Renumbered from 860-032-0670, PUC 5-2016, f. & cert. ef. 11-22-16

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Rule Caption: Rulemaking to Prescribe Application Requirements for Transportation Electrification Programs.
Adm. Order No.: PUC 6-2016
Filed with Sec. of State: 11-22-2016
Certified to be Effective: 11-22-16
Notice Publication Date: 8-1-2016
Rules Adopted: 860-087-0001, 860-087-0010, 860-087-0030, 860-087-0040
Subject: These rules implement section 20 of Senate Bill 1547 by prescribing the form and manner of electric companies applications for transportation electrification programs.
Rules Coordinator: Diane Davis—(503) 378-4372

860-087-0001
Scope and Applicability of Rules

(1) The rules in this division prescribe the application and reporting requirements for programs to accelerate transportation electrification filed by an electric company.

(2) Upon request or its own motion, the Commission may waive any of the rules in this division for good cause shown. A request for waiver must be made in writing, unless otherwise allowed by the Commission.

Stat. Auth.: ORS 756.040, 756.060, OL 2016, ch. 028, sects. 20, 29 (SB 1547)
Stats. Implemented: OL 2016, ch. 028, sects. 20, 29 (SB 1547)
Hist.: PUC 6-2016, f. & cert. ef. 11-22-16

860-087-0010
Definitions

For the purpose of this division:

(1) "Electric company" means an electric company as defined in ORS 757.600.

(2) "Transportation Electrification Program" means a program proposed by an electric company to accelerate transportation electrification.

Stat. Auth.: ORS 756.040, 756.060, OL 2016, ch. 028, sect. 20 (SB 1547)
Stats. Implemented: OL 2016, ch. 028, sect. 20 (SB 1547)
Hist.: PUC 6-2016, f. & cert. ef. 11-22-16

860-087-0030
Transportation Electrification Program Application Requirements

An electric company must file an application with the Commission for each program to accelerate transportation electrification.

(1) A Transportation Electrification Program application must include:

(a) A description of the program that includes, but is not limited to, a description of:

(A) Program elements, objectives, timeline, and expected outcomes;

(B) Market baseline assumptions;

(C) Major performance milestones;

(D) Where applicable, a description of program phases, including a proposal for when each subsequent program phase will be submitted for Commission review;

(E) Expected utilization, participation eligibility, and any incentive structures;

(F) Identification of market barriers, program implementation barriers, and program strategies to overcome the identified barriers;

(G) Description of the electric company's role and, if applicable, a discussion of how the electric company proposes to own or support charging infrastructure, billing services, metering, or customer information;

(H) Whether transportation electrification adoption attributed to the program will likely necessitate distribution system upgrades;

(I) Where applicable, a discussion of ownership structure;

(J) Where applicable, a discussion addressing interoperability of invested equipment;

(K) Where applicable, a discussion of any national standards for measurement and communication; and

(L) Any other information requested by the Commission.

(b) Data used to support the descriptions provided in paragraphs (1)(a)(A)-(L) of this rule.

(c) A description of program coordination that includes a description of:

(A) Stakeholder involvement in program development;

(B) Efforts to coordinate with related state programs;

(C) Coordination, if any, of delivery with other market actors and activities, and how the market and other market actors can leverage the underlying program or projects within the program.

(d) A description of the electric company's long-term strategy to accelerate transportation electrification in its service territory in an effective and efficient manner and how the proposed program fits within the long-term strategy. To the extent possible, the strategy description shall include, but not be limited to, a discussion of the following:

(A) The current condition of the transportation electrification market in the electric company's service territory and the outlook for development of the market in the absence of the proposed program;

(B) Near and long-term market barriers to the development of transportation electrification and how the electric company proposes specifically to address those barriers;

(C) Near and long-term opportunities for improving the operation and reliability of the electric company's power system through transportation electrification and how the electric company proposes specifically to take advantage of those opportunities; and

(D) Other factors pertinent to the electric company's plans for transportation electrification.

(e) A description of program costs that includes, but is not limited to:

(A) Estimated total program costs, including incentives, program delivery, evaluation, marketing, and administration costs;

(B) Estimated participant costs;

(C) How the electric company proposes to recover costs; and

(D) Any other information requested by the Commission.

(f) A description of the expected program benefits that includes, but is not limited to:

(A) Program benefits, including to whom and when benefits are accrued;

(B) Electrical system benefits; and

(C) A discussion of how a net benefit to ratepayers is attainable.

(g) A description of how the electric company will evaluate the program that includes, but is not limited to:

(A) Timeline of program evaluation and proposed evaluation reporting schedule;

(B) Estimated cost of evaluation;

(C) How the evaluation will be conducted and whether third-party evaluation is necessary;

(D) How the evaluation will address identified barriers; and

(E) A discussion of the method of data collection that is consistent with subsection (1)(b) of this rule and how the data will be used to evaluate the effectiveness of the program.

(F) Any other evaluative information requested by the Commission.

(h) A description of how the program addresses the considerations in Oregon Laws 2016, chapter 028, section 20(4)(a)-(f).

(2) An electric company must file applications for one or more Transportation Electrification Programs on or before December 31, 2016.

Stat. Auth.: ORS 756.040, 756.060, OL 2016, ch. 028, sects. 20, 29 (SB 1547)
Stats. Implemented: OL 2016, ch. 028, sects. 20, 29 (SB 1547)
Hist.: PUC 6-2016, f. & cert. ef. 11-22-16

860-087-0040
Transportation Electrification Program Reporting Requirements

(1) An electric company must report the results of its evaluation for each Transportation Electrification Program approved by the Commission. A program evaluation must include, but is not limited to:

(a) The information required under OAR 860-087-0030(1)(g)(A)-(F);

(b) An assessment of program costs and benefits realized by ratepayers and the electric company;

(c) A tracking of program costs over the life of the program;

(d) Progress against identified market barriers and implementation barriers;

(e) Current risk that investment will result in stranded costs;

(f) Whether any program modifications are recommended to help meet expected outcomes;

(g) Updated market data, including a description of changes in the condition of the transportation electrification market within the electric company's service territory; and

(h) An evaluation of whether and how the program has:

(A) Accelerated transportation electrification;

(B) Stimulated innovation, competition, and customer choice; and

(C) Supported system efficiency and operational flexibility, including the ability to integrate variable resources.

(2) The Commission may request additional program updates, including milestones and progress against success indicators, to assess whether to continue, discontinue, or modify approved Transportation Electrification Programs.

Stat. Auth.: ORS 756.040, 756.060, OL 2016, ch. 028, sect. 20 (SB 1547)
Stats. Implemented: OL 2016, ch. 028, sect. 20 (SB 1547)
Hist.: PUC 6-2016, f. & cert. ef. 11-22-16

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Rule Caption: In the Matter of Temporary Revisions to Residential Service Protection Fund Rules in Division 033.

Adm. Order No.: PUC 7-2016(Temp)
Filed with Sec. of State: 11-22-2016
Certified to be Effective: 12-2-16 thru 5-30-17
Notice Publication Date:
Rules Amended: 860-033-0005, 860-033-0030, 860-033-0046, 860-033-0050
Subject: These temporary rule changes conform to the new and streamlined Lifeline eligibility criteria adopted by the Federal Communications Commission in the Lifeline Modernization Order No. 16-38, effective December 2, 2016.
Rules Coordinator: Diane Davis—(503) 378-4372

860-033-0005
Definitions

For the purpose of this division:

(1) "Basic Service" means "basic telephone service" as defined in OAR 860-032-0190. For qualifying low-income recipients, basic service also includes access to toll-limitation services.

(2) "Competitive Provider" means a competitive telecommunications provider as defined in ORS 759.005(1) that provides services authorized under 759.020.

(3) "Cooperative" means a cooperative corporation or association that provides local exchange telecommunications service within its own exchanges, is organized under ORS Chapter 62, and is certified under 759.025(2).

(4) "Duplicate Support" means a customer is receiving OTAP or Lifeline supported services on two or more single lines or single line equivalents concurrently, or two or more customers in a household are receiving OTAP or Lifeline supported services concurrently.

(5) "Economic unit" means all adult individuals, eighteen or older, contributing to and sharing in the income and expenses of a household, including adult individuals with minimal or no income who benefit from another individual's financial support. Children under the age of eighteen living with their parents or guardians are considered to be part of the same household as their parents or guardians.

(6) "Eligible Telecommunications Carrier" means a provider of telecommunications service, including a cellular, wireless, or other radio common carrier, that is certified by order of the Commission as eligible to receive federal universal service support throughout a designated service area by having met the eligibility criteria set forth in 47 C.F.R. § 54 Subpart C (2012) and in orders of the Commission.

(7) "Eligible Telecommunications Provider" means a provider of telecommunications service, including a cellular, wireless, or other radio common carrier, that is certified by order of the Commission as eligible to provide OTAP to its qualifying customers throughout a designated service area by having met the following eligibility criteria:

(a) Offers services under 47 C.F.R. § 54 Subpart E (2013) using either its own facilities or a combination of its own facilities and resale of another carrier's services (including the services offered by another Eligible Telecommunications Carrier throughout the service area). Under 47 C.F.R. § 54 Subpart C (2012), the requirement of using its "own facilities" includes, but is not limited to, purchasing unbundled network elements from another carrier;

(b) Advertises the availability of and the charges for such services using media of general distribution; and

(c) Demonstrates that it will comply with OAR 860-033-0005 through 860-033-0110.

(8) "Household" means any individual or group of individuals, related or unrelated, who are living together at the same address as one economic unit.

(9) "Income" means gross income as defined under section 61 of the Internal Revenue Code, 26 USC § 61, for all members of the household from any source derived, unless specifically excluded by the Internal Revenue Code, Part III of Title 26, 26 USC § 101, et. seq.

(10) "Lifeline" means a program established by the Federal Communications Commission as defined in 47 C.F.R. § 54 Subpart E (2016).

(11) "Lifeline Household Worksheet" means a form that the Commission sends to an applicant when the Commission is unable to determine if an applicant and a current OTAP or Lifeline customer are part of a separate economic unit or household.

(12) "Local Exchange Service" means a "local exchange telecommunications service" as defined in ORS 759.005(3).

(13) "Low-income customer" means an individual who demonstrates eligibility for Lifeline supported services or the Oregon Telephone Assistance Program in OAR 860-033-0030.

(14) "Marketing materials" means all media, including but not limited to print, audio, video, Internet (including email, web, and social networking media), and outdoor signage, that describe the OTAP or Lifeline supported service offering.

(15) "Oregon Telephone Assistance Program" or "OTAP" means a program established by the Commission that offers reduced local exchange rates to eligible low-income residential customers. OTAP establishes the requirements for Eligible Telecommunications Carriers to offer Lifeline supported services in Oregon and may provide benefits that are in addition to those offered in Lifeline.

(16) "Oregon Telecommunications Relay Service" or "OTRS" means a facility authorized by the Commission to provide telecommunications relay service.

(17) "Outstanding Accounts" means amounts owing to the Commission including current accounts receivable and accounts that the Commission has written off through appropriate legal procedures. The term does not include amounts owing to the Commission that have been lawfully discharged through bankruptcy proceedings or amounts that are the subject of a proceeding pending before the Commission.

(18) "Residential Service Protection Fund" or "RSPF" means a legislatively approved fund in the Oregon State Treasury that supports the Oregon Telephone Assistance Program, the Telecommunication Devices Access Program and the Oregon Telecommunications Relay Service.

(19) "RSPF Surcharge" means a specified amount up to 35 cents per month collected from each paying retail subscriber who has telecommunications service with access to the telecommunications relay service, except as provided in OAR 850-033-0006(2).

(20) "RSPF Surcharge Exception Form" means the reporting form identified by that title that is available on the Commissions website at http://www.puc.state.or.us/Pages/telecom/rspf/index.aspx.

(21) "RSPF Surcharge Remittance Form 751" means the reporting form identified by that title that is available on the Commission's website at http://www.puc.state.or.us/Pages/telecom/rspf/index.aspx.

(22) "Service Initiation Date" means the date the low-income customer began receiving the OTAP or Lifeline benefit.

(23) "Service Type" means the following type of Lifeline supported service to which the low-income customer may subscribe pursuant to the minimum service standards defined in 47 C.F.R. § 54 Subpart E (2016):

(a) Voice telephony service only;

(b) Voice telephony service with broadband internet access service - (broadband internet access service does not meet the minimum service standards);

(c) Broadband internet access service only;

(d) Broadband internet access service with voice telephony service – (voice telephony service does not meet the minimum service standards); or

(e) Bundle – both voice telephony and broadband internet access service meet the minimum service standards.

(24) "Telecommunication Devices Access Program" or "TDAP" means a program established by the Commission that provides Assistive Telecommunication Devices or Adaptive Equipment at no additional cost beyond telephone service for customers who are deaf, hard of hearing, speech-impaired, deaf-blind or have a disability.

(25) "Telecommunications provider" includes competitive providers, cooperatives and telecommunications utilities.

(26) "Telecommunications service" means the offering of telecommunications as defined in 47 C.F.R. 54.5 (2012) for a fee directly to the public, or to such classes of users as to be effectively available directly to the public, regardless of the facilities used.

(27) "Telecommunications utility" means a person who is not a competitive provider and is designated as a telecommunications utility under OAR 860-032-0010.

(28) "Toll Limitation Service" means a service provided by an Eligible Telecommunications Provider that allows an OTAP recipient to choose to block the completion of outgoing toll calls (toll blocking) or to specify a certain toll usage that may be incurred per month or per billing cycle (toll control).

(29) "Tribal Lifeline" means a Lifeline service for eligible residents of Tribal lands as defined in 47 C.F.R. § 54 Subpart E (2013).

(30) "Tribal Link Up" means a federal assistance program for eligible residents of Tribal lands as defined in 47 C.F.R. § 54 Subpart E (2013).

(31) "Universal Service Administrative Company" means an independent, not-for-profit corporation designated by the Federal Communications Commission as the administrator of the universal service fund.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 7-1995(Temp), f. & cert. ef. 8-17-95 (Order No. 95-860); PUC 14-1995, f. & cert. ef. 12-20-95 (Order No. 95-1328); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 18-2000, f. & cert. ef. 10-24-00; PUC 4-2001, f. & cert. ef. 1-24-01; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13; PUC 7-2013, f. & cert. ef. 12-20-13; PUC 7-2016(Temp), f. 11-22-16, cert. ef. 12-2-16 thru 5-30-17

860-033-0030
OTAP and Lifeline Eligibility

(1) A low-income customer demonstrates eligibility for OTAP and Lifeline by application to the Commission on a Commission-approved form demonstrating compliance with this rule.

(2) To be eligible, the customer, one or more of the customer's dependents or the customer's household must:

(a) Receive benefits from one of the following public assistance programs: Medicaid under Title XIX and XXI of the Social Security Act; Supplemental Nutrition Assistance Program; Supplemental Security Income; Federal Public Housing Assistance (Section 8); or Veterans and Survivors Pension Benefit; or

(b) Have income that is at or below 135 percent of the applicable Federal Poverty Guidelines for a household of that size.

(3) The Commission may require a low-income customer to submit documentation demonstrating that he or she qualifies under the program or income based eligibility requirements.

(a) Acceptable documentation of program eligibility includes the current or prior year's statement of benefits from a public assistance program, a notice or letter of participation in a public assistance program, program participation documents, or another official document demonstrating that the customer, one or more of the customer's dependents or the customer's household receives benefits from a qualifying assistance program.

(b) Acceptable documentation of income eligibility includes the prior year's state, federal, or Tribal tax return; current income statement from an employer or paycheck stub; a Social Security statement of benefits; a Veterans Administration statement of benefits; a retirement or pension statement of benefits; an Unemployment or Workers' Compensation statement of benefit; federal or Tribal notice letter of participation in General Assistance; or a divorce decree, child support award, or other official document containing income information. If the customer presents documentation of income that does not cover a full year, such as current pay stubs, the customer must present the same type of documentation covering three consecutive months within the previous twelve months.

(4) The customer may be required to furnish his or her social security number and the social security number of the member of the customer's household upon whom eligibility is based before OTAP and Lifeline eligibility can be determined or verified. Failure to do so may result in denial of benefits.

(5) The customer must sign a written authorization on a Commission-approved form permitting the Commission to release necessary information to an Eligible Telecommunications Provider and, as necessary, to the following: Federal Communications Commission, Universal Service Administrative Company, Department of Human Services, and the applicant's personal representative or legal guardian.

(6) An applicant or customer may not use a post office box as his or her residential address. The Commission may accept a P.O. Box or General Delivery address as a billing address, but not a residential address.

(7) The OTAP or Lifeline benefit is limited to one single line, or single line equivalent, per economic unit at the customer's principal residence in Oregon.

(a) If the Commission is unable to determine that an applicant and a current OTAP or Lifeline customer are part of a separate household, the applicant must complete and submit to the Commission the Lifeline Household Worksheet.

(b) The Commission may verify annually that the customer continues to be part of a separate household.

(c) If the customer fails to respond within 30 days of the Commission's attempts to verify that the customer continues to be part of a separate household, the Commission will notify the Eligible Telecommunications Provider to de-enroll the customer from OTAP and the Lifeline program.

(8) The name of the OTAP or Lifeline applicant must appear on the billing statement or account for the telecommunications service in order for that for that applicant to qualify for OTAP or Lifeline benefits.

(9) The Commission may require an Eligible Telecommunications Provider to provide up to three months of OTAP or Lifeline benefits credited to the customer's account if the customer does not receive benefits after applying for benefits and demonstrating eligibility. The qualifying customer may be required to submit documentation demonstrating that he or she qualified under the program or income based eligibility requirements in section (2) or (3) of this rule.

(10) The Commission will verify a customer's continuing eligibility. Continuing OTAP and Lifeline eligibility is based on monthly, quarterly, or annual verification by the Commission.

(a) The Commission will allow a customer 30 days following the date of the notice of termination or de-enrollment to demonstrate continued eligibility. A customer may be required to submit proof of continued eligibility to the Commission.

(b) The Eligible Telecommunications Provider must de-enroll the customer from the OTAP and Lifeline program within five business days of notice from the Commission that the customer is no longer eligible for OTAP and the Lifeline program.

(c) After the Commission determines that the customer is not eligible or no longer eligible, the customer may file a written request for a hearing to appeal the determination as specified in the notice of determination.

(d) At the hearing, the customer must provide to the Commission documentation demonstrating that he or she qualifies under the program or income based eligibility requirements listed in section (2) or (3) of this rule.

(11) If the Commission identifies that a customer or household is receiving duplicate support from more than one Eligible Telecommunications Provider, the Commission will attempt to contact the customer to determine the customer's preferred provider and thereafter, based on the available information, select which Eligible Telecommunications Provider must de-enroll the customer.

(12) If a customer does not use the OTAP or Lifeline supported service that the Eligible Telecommunications Provider offers at no charge per the usage requirements defined in 47 C.F.R. § 54 Subpart E (2016) for 30 consecutive days, the Eligible Telecommunications Provider must provide the customer 15 days' notice, using plain language, that the customer's failure to use the OTAP or Lifeline supported service within the 15-day notice period will result in de-enrollment from OTAP or the Lifeline program. If the customer uses the OTAP or the Lifeline supported service within the 15-day notice period, the Eligible Telecommunications Provider may not terminate the customer's OTAP or Lifeline supported service.

(13) When the customer switches to a different Eligible Telecommunications Provider, the customer must submit to the Commission an application for OTAP or the Lifeline program on a Commission-approved form.

(14) If, in a span of 30 days, the customer disconnects and reconnects service with the same Eligible Telecommunications Provider, the customer is not required to reapply for the OTAP or Lifeline benefits.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 5-1992, f. & ef. 2-14-92 (Order No. 92-238); PUC 11-1995, f. & ef. 11-27-95 (Order No. 95-1217); PUC 6-1997, f. & ef. 1-10-97 (Order No. 97-005); PUC 6-1997, f. & cert. ef. 1-10-97; PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-1999, f. & cert. ef. 11-18-99; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13; PUC 7-2013, f. & cert. ef. 12-20-13; PUC 7-2016(Temp), f. 11-22-16, cert. ef. 12-2-16 thru 5-30-17

860-033-0046
OTAP and Lifeline Accounting, Reporting and Auditing

(1) Based upon accounting procedures approved by the Commission, Eligible Telecommunications Providers must maintain accounting records so that costs associated with OTAP and Lifeline can be separately identified. Records must be provided to the Commission upon request.

(2) Active OTAP and Lifeline Customer Report: The Active OTAP and Lifeline Customer Report is a listing of all customers receiving the OTAP or Lifeline benefit. The listing may include the customers' telephone numbers, addresses, service types, or Commission-assigned OTAP Identification Number. Each Eligible Telecommunications Provider must submit monthly to the Commission in an electronic format accessible by the Commission, an Active OTAP and Lifeline Customer Report. The Active OTAP and Lifeline Customer Report must be received by the Commission on or before the close of business on the 21st calendar day of the following month.

(3) Order Activity Report: The Order Activity Report is a listing of all OTAP or Lifeline customers whose phone service was disconnected, who voluntarily de-enrolled or were de-enrolled for failure to use the OTAP or Lifeline supported service that the Eligible Telecommunications Provider offers at no charge, and a listing of all OTAP or Lifeline customers whose telephone numbers, addresses, or service initiation dates and service types have changed. Except as specified in subsection (5) of this rule, each Eligible Telecommunications Provider must submit weekly to the Commission in an electronic format accessible by the Commission an Order Activity Report. An Eligible Telecommunications Provider submitting the Order Activity Report on a monthly basis as of December 1, 2016, may continue to report on a monthly basis. The Eligible Telecommunications Provider does not need to submit the Order Activity Report if there is no activity for the week.

(4) No Match Report: When the Commission notifies the Eligible Telecommunications Provider of customers who meet eligibility criteria, the Eligible Telecommunications Provider must submit an electronic No Match Report in a format accessible by the Commission that contains the following:

(a) Any discrepancy that prevents a customer from receiving the OTAP or Lifeline benefit; and

(b) The Commission-approved low-income customer's service initiation date and service type.

(5) When the Commission issues an order designating a provider of telecommunications service as an Eligible Telecommunications Provider and thereby adopts the terms of a stipulation setting specific requirements for reporting Order Activity and No Match that are different from sections (3) and (4) of this rule, the Eligible Telecommunications Provider may report Order Activity and No Match in a manner consistent with the terms of the stipulation approved by the Commission.

(6) The Commission reserves the right to audit the records of an Eligible Telecommunications Provider that provides OTAP or Lifeline benefits.

(7) OTAP and Lifeline Records: Each Eligible Telecommunications Provider must keep all OTAP and Lifeline records and supporting documentation for three years, or if a Commission review or audit is pending, until the review or audit is complete, whichever is later.

(a) An Eligible Telecommunications Provider must produce for inspection or audit upon request of the Commission or its authorized representative all OTAP and Lifeline records and supporting documentation. The Commission, or its representative, must allow the Eligible Telecommunications Provider a reasonable time to produce the records for inspection or audit.

(b) In addition to any other penalty allowed by law, the Commission may suspend or cancel an Eligible Telecommunications Provider's certificate of authority to provide telecommunications service for its failure to produce for inspection or audit the records required by this rule.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13; PUC 7-2013, f. & cert. ef. 12-20-13; PUC 7-2016(Temp), f. 11-22-16, cert. ef. 12-2-16 thru 5-30-17

860-033-0050
Tribal Lifeline and Tribal Link-Up

(1) The Commission must determine if a prospective Tribal Lifeline or Tribal Link Up recipient who has executed a certification pursuant to 47 C.F.R. § 54 Subpart E (2013) has previously received a Tribal Lifeline or Tribal Link Up benefit at the residential address provided by the prospective subscriber to prevent duplicative support. An eligible resident of Tribal lands may receive the benefit of the Tribal Link Up program for a second or subsequent time only for otherwise qualifying commencement of telecommunications service at a principal place of residence with an address different from the address for which Tribal Link Up assistance was previously provided.

(2) Within five business days of a request for Tribal Lifeline or Tribal Link Up benefit, the Eligible Telecommunications Provider must submit to the Commission in an electronic format accessible by the Commission the Tribal Lifeline or Tribal Link Up applicant's full name, residential address, date of birth, telephone number associated with the application for Tribal Lifeline or Tribal Link Up benefit, and last four digits of his or her social security number or Tribal identification number. Each Eligible Telecommunications Provider must obtain, from each new and existing subscriber, consent to transmit the information as specified in this section of this rule. Prior to obtaining consent, the Eligible Telecommunications Provider must describe to the subscriber, using plain language, the specific information being submitted, that the information is being submitted to the Commission to ensure proper administration of the Tribal Lifeline and Tribal Link Up program, and that failure to provide consent will result in the subscriber being denied the Tribal Lifeline or Tribal Link Up benefit.

(3) If the Commission notifies the Eligible Telecommunications Provider that a prospective subscriber is receiving a Tribal Lifeline benefit or has received a Tribal Link Up benefit at the residential address provided by the subscriber, the Eligible Telecommunications Provider may not seek universal service support reimbursement for duplicate service.

(4) If the Commission notifies the Eligible Telecommunications Provider that a prospective subscriber is not receiving a Tribal Lifeline benefit or has not received a Tribal Link Up benefit at the residential address provided by the subscriber, the Eligible Telecommunications Provider must provide the customer's service initiation date and service type.

(5) When two or more Eligible Telecommunications Providers submit the information required in section (2) of this rule for the same subscriber, only the Eligible Telecommunications Provider whose information was received and processed by the Commission first, as determined by the Commission, will be entitled to reimbursement from the universal service fund for that subscriber.

(6) Tribal Lifeline and Tribal Link Up Order Activity Report: The Tribal Lifeline and Tribal Link Up Order Activity Report is a listing of all Tribal Lifeline and Tribal Link Up customers whose phone service was disconnected, who voluntarily de-enrolled or were de-enrolled for failure to use the Tribal Lifeline service which the Eligible Telecommunications Provider offers at no charge and a list of all Tribal Lifeline and Tribal Link Up customers whose telephone numbers, addresses, or service initiation dates and service types have changed. Each Eligible Telecommunications Provider must submit weekly to the Commission in an electronic format accessible by the Commission. An Eligible Telecommunications Provider submitting the Tribal Lifeline and Tribal Link Up Order Activity Report on a monthly bases as of December 1, 2016, may continue to report on a monthly basis. The Eligible Telecommunications Provider does not need to submit the Order Activity Report if there is no activity for the week.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 8-1989, f. & cert. ef. 6-8-89 (Order No. 89-724); PUC 5-1992, f. & ef. 2-14-92 (Order No. 92-238); PUC 2-1996, f. & ef. 4-18-96 (Order 96-102); PUC 6-1997, f. & cert. ef. 1-10-97; PUC 18-1997, f. & cert. ef. 12-17-97; PUC 2-2002, f. & cert. ef. 2-5-02; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13; PUC 7-2013, f. & cert. ef. 12-20-13; PUC 7-2016(Temp), f. 11-22-16, cert. ef. 12-2-16 thru 5-30-17

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Public Utility Commission, Board of Maritime Pilots
Chapter 856

Rule Caption: Changes timing of annual TOC adjustment to coincide with annual COLA adjustment.
Adm. Order No.: BMP 7-2016
Filed with Sec. of State: 11-22-2016
Certified to be Effective: 11-22-16
Notice Publication Date: 11-1-2016
Rules Amended: 856-030-0040
Subject: These amendments change the effective dates of the annual transportation cost adjustment to the tariff to coincide with the annual cost-of-living adjustment. The amendment was previously adopted as a temporary rule because there was not enough time to go through regular rulemaking for it to be in effect at the time of the adjustment. The amendment was noticed again through the regular rulemaking process as the temporary rule was set to expire on 11/20/16.
Rules Coordinator: Susan Johnson—(971) 673-1530

856-030-0040
Transportation Oversight Committee

(1) For the purpose of making annual, automatic, cost-based adjustments to the transportation system cost component of the tariff funding the pilotage system for the Columbia River Bar pilotage grounds, a Transportation Oversight Committee is established, composed of one public member of the Oregon Board of Maritime Pilots (Board), two members of the Columbia River Bar Pilots (CRBP), a representative of the Columbia River Steamship Operators Association and a representative of a port located on the Columbia River. The public member of the Transportation Oversight Committee will act as chair.

(2) Beginning in 2011, the Transportation Oversight Committee will meet as necessary but at least semiannually. The Transportation Oversight Committee will perform long-term transportation system planning, will regularly review transportation system costs and operations, and will make recommendations regarding the operation of the transportation system, for the Columbia River Bar pilotage grounds.

(3) Upon agreement of a majority of members, the Transportation Oversight Committee may submit data requests to the CRBP. Data requests are written interrogatories or requests for production of documents. The data requests must be answered within 20 Board business days from the date of service. Each data request must be answered fully and separately in writing or by production of documents.

(4) On an annual basis beginning in 2011, the Transportation Oversight Committee shall make a recommendation to the Board regarding annual adjustments to the components of the Transportation System Cost of the pilotage system serving the Columbia River Bar pilotage grounds to reflect the best available information about changing economic conditions including expense levels shown by CRBP financial statements and Transportation Oversight Committee projections. The Transportation System Cost components include the following line item categories: helicopter service; repairs and maintenance infrastructure; repairs and maintenance; insurance; boat operator expense; employee wages; employee benefits; transportation launch expense; food vessel expense; taxes and licenses; and administrative/accounting. The recommended adjustments to one or more of the components of the Transportation System Cost shall be developed by the Transportation Oversight Committee and submitted in writing to the Board by July 31 of each year.

(5) In the event the Transportation Oversight Committee cannot reach agreement on one or more of the components of the Transportation System Cost, the competing views shall be described in appropriate memoranda drafted by one or more representative of the Transportation Oversight Committee and submitted to the Oregon Board of Maritime Pilots. The submission from the Transportation Oversight Committee shall be considered by the Oregon Board of Maritime Pilots at a meeting that occurs on or before August 31 of each year so that the Committee's recommendations can be considered and any disputed issue decided in order for any adjustments to the components of the Transportation System cost to be effective on September 1 of that year.

Stat. Auth.: ORS 776, 670
Stats. Implemented: ORS 776.115, 670.310
Hist.: BMP 2-2011, f. 6-28-11, cert. ef. 6-29-11; BMP 4-2016(Temp), f. & cert. ef. 5-25-16 thru 11-20-16; BMP 7-2016, f. & cert. ef. 11-22-16

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Southern Oregon University
Chapter 573

Rule Caption: Parking Regulations
Adm. Order No.: SOU 15-2016
Filed with Sec. of State: 12-6-2016
Certified to be Effective: 12-6-16
Notice Publication Date: 11-1-2016
Rules Amended: 573-050-0015, 573-050-0016, 573-050-0025, 573-050-0040, 573-050-0045
Subject: this amendment in Div. 050 edits language to correct subsections of the rule.
Rules Coordinator: Treasa Sprague—(541) 552-6319

573-050-0015
Definitions

(1) For the purpose of these regulations, the word "parking" means any vehicle which is stopped and/or waiting, regardless of the period of time the vehicle is stopped or whether a driver is present, except for a vehicle immobilized by traffic control, congestion, or accident.

(2) The word "vehicle" means any type of motor-powered conveyance including, but not limited to, automobiles, trucks, trailers, motorcycles, mopeds, scooters, bicycles, skateboards, personal assistive mobility devices and all methods of transportation on wheels.

(3) The word "permit" as used in these regulations includes all the following:

(a) Faculty/Staff decal/hang tag.
(b) Student Commuter decal;
(c) Residence Hall decal;
(d) Motorcycle and Scooter decal;
(e) Carpool decal;
(f) Temporary Substitute permit;
(g) Weekly Parking permit;
(h) Guest Parking permit;
(i) Service Vehicle permit;
(j) Daily Parking permit.
(k) Special Permits

(l) Meter Receipt Permits

(4) A "decal" is the permanent permit affixed to a vehicle.

(5) The word "permit" means a valid decal or permit as recognized by the Parking Department.

(6) Service vehicles are defined as University-owned service trucks or cars, vehicles with commercial permits, or vehicles with special temporary service permits performing a service for Southern Oregon University.

(7) Delivery vehicles are defined as vehicles owned by companies doing pick-up and delivery business with the University departments or vehicles with temporary special delivery permits on pick-up and delivery business.

(8) Dangerous driving includes but is not limited to wrong way driving, high speed, spinning tires or operating a vehicle not under control.

Stat. Auth.: ORS 351.070

Stats. Implemented: ORS 352.360

Hist.: SOSC 5, f. & ef. 9-2-76; SOSC 4-1979, f. 8-8-79, ef. 9-1-79; SOSC 5-1980, f. & ef. 8-19-80; SOSC 4-1982, f. & ef. 7-28-82; SOSC 6-1983, f. & ef. 8-23-83; SOSC 2-1984, f. & ef. 8-14-84; SOSC 8-1985, f. & ef. 8-12-85; SOSC 5-1987, f. & ef. 9-8-87; SOSC 2-1996, f. & cert. ef. 8-2-96; SOU 2-2011, f. & cert. ef. 6-13-11; SOU 2-2012, f. & cert. ef. 6-11-12; SOU 3-2013, f. & cert. ef. 6-20-13; SOU 15-2016, f. & cert. ef. 12-6-16

573-050-0016

Service Vehicles, Delivery Vehicles, and Loading Zones

(1) Loading Zones:

(a) Loading zones are located throughout the campus and are reserved for people loading and unloading heavy or bulky packages;

(b) Signed loading zones are limited to 30-minute occupancy;

(c) Loading zones are enforced at all times unless otherwise posted.

(2) Loading Docks:

(a) Loading docks are reserved for delivery vehicles;

(b) Under special circumstances, a private vehicle may be issued special use permission at Campus Public Safety;

(c) Loading docks are enforced at all times unless otherwise posted.

(3) Service Vehicles Spaces:

(a) Spaces are reserved for service vehicles;

(b) Under special circumstances, a private vehicle may be issued special use permission to park in a non-designated parking space from the CPS/Parking Director. Vehicles must get permission from the director prior to parking on campus.

Stat. Auth.: ORS 351.070

Stats. Implemented: ORS 352.360

Hist.: SOU 2-2011, f. & cert. ef. 6-13-11; SOU 3-2013, f. & cert. ef. 6-20-13; SOU 15-2016, f. & cert. ef. 12-6-16

573-050-0025

Vehicle Permits, Parking Areas and Fee Schedule

(1) All vehicles parked on the University campus are required to display a valid SOU permit when the posted signs require a permit. Faculty/Staff lots are posted yellow; Student Commuter lots are posted green; Resident Student lots are posted red. Parking Services can be contacted for the location where other types of permits may be obtained. Failure to display a permit may result in the issuance of a parking citation. Faculty/Staff hangtags, commuter decals, and resident decals can be purchased on the SOU parking website only. Once ordered, decals/hangtag permits are to be picked up at enrollment services in Britt Hall the following business day. Permits will not be mailed to personal addresses, or via campus mail services. Visitor/Guest Permits may be purchased 24 hours a day at any of the parking meters. All permits are valid for the current academic year only, unless otherwise designated by Parking Services at the time of issuance; there are no open-ended permits. Permit is defined as any Parking Services sanctioned or issued permit. Examples include: decal, hangtag, guest, metered, temporary, courtesy*, media, or other placard or device issued or developed by Parking Services as needed to facilitate parking of vehicles on Southern Oregon University property. *(A courtesy permit refers to a Retiree, VIP, or a Volunteer.) Any misuse of these parking permits may cause them to be revoked.

(2) Parking permits and faculty/staff hangtags are serialized for use on specific vehicle(s) with a license plate designated by the purchaser at the time of purchase. Permits (decals) must be affixed outside to left-rear bumper, left-rear body, left-rear window, or rear-side window behind driver of the vehicle where visible. The adhesive on the back of the permit must be the attaching mechanism. Hangtags are to be hung from the rear-view mirror; serialized numbers facing out. Parking Services (at the Enrollment Services Center in Britt Hall) must be informed of changes in vehicles; re-registering the hangtags to the appropriate vehicle(s). A maximum of three vehicles may be registered to one hangtag. Those three vehicles must be registered to the owner or his/her spouse. Hangtags are not to be shared with others. If a vehicle is disposed of, the permit must be removed and returned to Parking Services.

(3) Parking permits may be purchased for the time period designated on the decals; generally, the academic year. The academic year begins and ends in September. Parking permits purchased during the winter, spring, or summer terms are at a proportionately reduced rate.

(4) Faculty/Staff (yellow) parking permits (or hangtags) will be sold to classified employees, graduate assistants, temporary employees who are half-time or more, and faculty. Faculty/staff employees working .50 FTE or less will be eligible for a permit at a reduced rate of one-half the cost of the permit. Hangtags are issued for a three-year period. Faculty/staff hangtags are considered the first permit. They are not to be sold as a second permit. Vehicles displaying a Faculty/Staff permit (yellow) (or hangtag) are authorized to park in designated Faculty/Staff (yellow) parking areas or Student parking areas (red parking areas or green parking areas).

(5) Student Commuter parking (green) permits will be sold to students who live off campus and wish to bring vehicles on campus. Vehicles displaying a Student Commuter permit are authorized to park in designated Student Commuter (green) parking areas.

(6) Residence Hall (red) parking permits will be sold to students living in campus residence halls. Vehicles displaying a Residence Hall permit are authorized to park in designated Residence Hall (red) parking areas.

(7) Second parking permits may be purchased for an additional vehicle if more than one vehicle will be brought to campus. The purchaser must also be the registered owner of the vehicle. Only one permit (the original or second permit) is valid in permit-required lots at a time. If both first and second permits of one person are parked in permit-required lots at the same time, both vehicles will be cited for improper permits. A second permit may not be purchased for a car if the first permit is for a vehicle used in a Residence Hall Parking area, a motorcycle, moped, or scooter.

(8) A replacement permit may be obtained for a damaged, unreadable permit or for a replacement vehicle. The replacement vehicle must be registered to the same owner as the original vehicle. The permit which is being replaced will be considered void and should be returned to Parking Services (at the Enrollment Services Center in Britt Hall) There is no charge for lost, stolen, or destroyed permits; however, it must be reported to CPS if there is evidence of possible theft.

(9) Hourly, daily, and weekly permits for visitors/guests are to be purchased at a parking meter. Parking Services will no longer issue department guest pass booklets, however departments can finish out the guest pass books they currently have. Departments will now use meter codes. Departments that wish to pay for their visitor parking will receive the code to give to their guests. When entered at one of the parking meters, it will then print out a parking permit with no charge. At the end of the month the parking manager will pull a report of how many times that code was used, and then charge the department. The codes will expire at the end of the month, and a new code will be issued for the next month. The department is responsible for giving out their meter code to guests, and are therefore responsible for any misuse. The department is required to pay the fees based on the amount of times the code was used. At any point the department can request to have their code deactivated. Meter codes may also be programmed to be limited in number of uses, based on departmental needs. Guest permits may not be used in timed or visitor pay meter lots. Guest permits will not be valid if issued to University employees, faculty, students, buses, or vehicles displaying a valid parking permit. For those departments still issuing their guest passes: Guest permits will not be valid and a citation may be issued for failure to display permit if any of the following information is illegible or omitted:

(a) Both license number and make or color of vehicle;

(b) Date that permit is valid;

(c) Name and telephone extension of departmental personnel issuing the permit.

(d) Must be written in ink.

(10) Carpool parking permits will be sold for the entire school year only if the carpool meets the following criteria:

(a) The carpool must contain at least two registered participants but no more than six.

(b) No more than one vehicle from the carpool is allowed on campus at a particular time. They may not purchase a second permit. However, replacement permits are available if requirements as stated in the regulations for replacement permits are met.

(11) Temporary replacement vehicles for a vehicle with a permit may be brought on campus after obtaining a Substitute Vehicle parking permit from Parking Services. This permit is used for temporary situations of short duration (15 days or less).

(12) Special permits may be approved by Parking Services on an as-needed basis.

(13) Visitor/guest meter Permits may be purchased at any of the parking meters. Hourly pass: $1.00 per hour, Daily pass: $10.00, 3-day pass: $20, 7-day pass: $30.00.

(14) Courtesy (purple), parking permits are available to Emeritus Faculty only. Courtesy (purple), permits are valid for Emeritus Faculty only, not to be used by family or friends. A grandfather clause exists for employees who have already received a purple permit prior to the effective date of this rule. Volunteer board members, designated governmental officials, media representatives, and such others as deemed necessary by the President will have dated and numbered VIP hangtags to facilitate their interaction with the institution. Media representatives will receive dated and numbered hangtags. Permits may be used only for their intended purpose.

(15) Commercial Permits:

(a) Commercial permits will be sold to commercial vendors, including vending machine, video game, outside maintenance, travel, office supply, and food vendor companies, and contractors' employees. Companies or departments can purchase a long-term permit for six months or a year. Short-term permits are available for one day or one month. Companies or departments will be billed for the permits by Parking Services via meter code.

(b) Volunteer parking permits will be issued to departments for use by volunteers. Volunteer permits may be issued for a period of six months. There is no charge. Volunteer permits are not valid if issued to current University employees, faculty or students.

(16) Disabled parking is in accordance with ORS 811.602, 811.605, 811.606, 811.607, and 811.615. Only vehicles displaying a valid disabled placard or license plate issued and registered at the Motor Vehicles Division (as designated in Rule 573-050-0020) will be allowed to park in spaces posted for use by disabled persons. These vehicles must also display an SOU permit or meter permit unless otherwise posted.

(a) Temporary placards are issued by the Motor Vehicle Division for persons with qualifying temporary disabilities (as provided by ORS 811.606 and 811.640). The requirements for parking on campus apply for all disabled parking listed above.

(b) Vehicles with a valid disabled placard or license plate and SOU permit may park in any lot or space without incurring citations, except timed spaces or reserved spaces.

(17) Refunds will be given for student/staff parking permits for unused academic terms, except summer term. No refunds will be given for year permits that are not used summer term. Permits cannot be purchased for a single term only. Refunds will be given upon return of the permit or fragments thereof showing the permit numbers and expiration date. Refund schedules are on file at ESC.

(18) Vehicles displaying valid permits are not guaranteed a parking space on the campus.

(19) Vehicles displaying valid permits are not exempt from timed parking restrictions. Timed spaces are limited and are intended for visitors with SOU business and/or seeking to enroll at Southern Oregon University. Vehicles with valid permits may park in a metered parking space but must comply with the time limits or metered fee payment of the specific space. Vehicles displaying valid permits must still purchase a valid meter permit to park in spots that are posted with signs saying "Visitor Parking, Pay at Meter."

(20) Mopeds, scooters, & motorcycles must have a motorcycle permit and be parked in a motorcycle parking space. If a motorcycle has a full price vehicle parking permit they may park in a vehicle space that corresponds with the color of the permit. Motorcycles may park in timed spaces that are open to the public. Mopeds, scooters, and motorcycles parked in bicycle racks and on the campus grounds will be cited for improper parking. Vehicles parked inside University buildings will be towed at the owner's expense.

(21) If a faculty/staff hangtag is the first legal permit, and a motorcycle is the second vehicle, a decal may be purchased at second decal rate.

(22) If, during the process of issuing a parking citation, the driver of the violating vehicle drives away from the scene, thus preventing the issuing agent from placing the citation on the vehicle, the citation will be entered into the parking system as if it had been placed on the vehicle. When a driver leaves the scene during the issuing process, this will be considered "constructive notice" of the citation.

(23) Vehicles parked facing in the direction against one-way arrows will be cited for improper parking. Vehicles parked on the side of street opposing direction of usual traffic flow will be cited for improper parking.

(24) Vehicles using parking lots marked "Pay Parking" are required to display the serialized meter permit purchased at each lot of this type. Failure to display the meter permit in plain view on the left side of the vehicle's dashboard will result in a citation for failure to display a permit. There is no grace period to obtain change for the permit machine.

(25) Government Vehicles not assigned a permanent parking space may only be parked for a period of 24 hours in Faculty/Staff or Student parking spaces unless prior permission has been obtained from Parking Services. Vehicles may be liable for enforcement action for non-compliance. Government vehicles are not exempt from parking in timed spaces for periods longer than the amount of time posted on the signs.

(26) Buses may park where directed by Parking Services.

(27) Fee Schedule:

(a) Carpool, sold for entire school year only: $135 each pool.

(b) Faculty and staff decal for first-registered vehicle, fall term through summer term: $150.

(c) Faculty/staff hangtags are issued for a three-year period: $439.

(A) This fee is for a one-time purchase. Proration is available for the second and third year.

(B) Payroll deduction is available, plus applicable increases in permit fees.

(d) Student Commuter and Residence Hall decal for first-registered vehicle for only fall term through summer term: $140.

(e) Motorcycles, mopeds, and scooters, one vehicle only:

(A) Fall term through summer term: $57.

(B) If motorcycles park in auto spaces, the fee is commensurate with full auto fee for the area.

(f) Second Vehicle permit: $49,

(A) Second permits will be sold only to Faculty/Staff and Commuter permit holders. Red permit holders may not purchase a second permit.

(B) One second permit is allowed for each full-price (first-registered vehicle) permit purchased.

(C) Replacement permits can be obtained only in accordance with OAR 573-050-0025(8).

(g) Replacement permits or hangtags: $30.

(h) Lost, stolen, or destroyed permits: No fee. Any evidence of theft must be reported to Campus Public Safety before receiving the new permit.

(i) Departmental Reserved Parking spaces (nonrefundable): $100 over and above price for regular parking permit and a $50 fee for each subsequent sign-change after a sign is posted.

(j) Commercial permit, each vehicle:

(A) Long-term, twelve months: $ 250.

(B) Long-term, six months: $180.

(C) Short-term, one month: $60.

(D) Short-term, daily: $10.

(k) Weekly parking permits: $30 per week available at the parking meters.

(l) Daily parking permits: $10 per day available at the parking meters.

(m) Three-day parking permits: $20 available at the parking meters.

(n) Volunteer permit: No fee. Valid for 6 months. Volunteer permits may not be issued to current students, faculty, or staff. To obtain a volunteer parking pass, the department must email the SOU parking department and they will receive a parking meter code that will be created for each volunteer.

(o) Handling charges:

(A) Deducting fines from payroll check: $ 8.

(B) Out-of-state Department of Motor Vehicles research fee: $10. Parking meter locations: 1, 3, 12, 29, 36 and 37 takes coin or card, and can print out long term permits. Lot 41 has a meter that takes cash or coin, and can only print hourly permits. The meter price rates are universal on all meters on campus. Valid meter permits may be used in any metered lot, and are not limited to parking only in the lot where the permit was purchased.

Stat. Auth.: ORS 351.070

Stats. Implemented: ORS 352.360

Hist.: SOSC 5, f. & ef. 9-2-76; SOSC 4-1979, f. 8-8-79, ef. 9-1-79; SOSC 5-1980, f. & ef. 8-19-80; SOSC 3-1981, f. & ef. 9-9-81; SOSC 4-1982, f. & ef. 7-28-82; SOSC 1-1983, f. & ef. 1-3-83; SOSC 6-1983, f. & ef. 8-23-83; SOSC 2-1984, f. & ef. 8-14-84; SOSC 8-1985, f. & ef. 8-12-85; SOSC 3-1986, f. & ef. 7-22-86; SOSC 5-1987, f. & ef. 9-8-87; SOSC 4-1989, f. & cert. ef. 9-19-89; SOSC 3-1990, f. & cert. ef. 5-31-90; SOSC 4-1991, f. & cert. ef. 6-11-91; SOSC 2-1994, f. & cert. ef. 6-10-94; SOSC 2-1996, f. & cert. ef. 8-2-96; SOU 2-1997, f. & cert. ef. 8-26-97; SOU 2-1998, f. & cert. ef. 7-16-98; SOU 1-1999, f. & cert. ef. 5-7-99; SOU 2-2000, f. & cert. ef. 6-9-00; SOU 1-2001, f. & cert. ef. 4-4-01; SOU 2-2002, f. & cert. ef. 6-28-02; SOU 1-2004, f. & cert. ef. 4-5-04; SOU 3-2006, f. & cert. ef. 6-29-06; SOU 3-2007, f. & cert. ef. 7-23-07; SOU 3-2009, f. 10-1-09, cert. ef. 10-4-09; SOU 3-2010, f. & cert. ef. 6-8-10; SOU 2-2011, f. & cert. ef. 6-13-11; SOU 2-2012, f. & cert. ef. 6-11-12; SOU 3-2013, f. & cert. ef. 6-20-13; SOU 3-2014, f. & cert. ef. 7-2-14; SOU 2-2015, f. & cert. ef. 6-5-15; SOU 2-2016, f. & cert. ef. 5-4-16; SOU 15-2016, f. & cert. ef. 12-6-16

573-050-0040
Penalties for Offenses

Multiple violations may be cited for a single incident:

(1) Failure to display valid permit: Fine $30.

(2) Fraudulent display of permit: Fine $85.

(3) Permit not affixed: Fine $25.

(4) Improper permit: Fine $20.

(5) Parking in disabled space: $450.

(6) Overtime parking: Fine $25.

(7) Blocking wheel chair ramp: Fine $100.

(8) Improper parking: Fine $30.

(9) Parking in reserved space: Fine $75.

(10) Blocking traffic: Fine $50.

(11) Boot vehicle: Fine $50.00

(12) Abandoning a vehicle: Fine $100.

(13) Meter permit expired: Fine $10. (Note: this violation is only for vehicles that purchased a meter permit that same calendar day. Vehicles displaying expired meter permits from previous days receive the $30.00 fine for having no permit displayed).

(14) Failure to display a license plate or valid temporary license plate: $25.

(15) A vehicle may be towed off campus property and impounded at the owner's expense (including additional fines) under the following circumstances:

(a) Any vehicle is causing imminent danger to people or University property;

(b) Any vehicle is without a valid yellow, green, or red parking permit and has records of $100 or more in unpaid citations (may be towed or booted);

(c) Any vehicle is left parked or standing in an area not normally used for parking, including parking on a sidewalk or on grass;

(d) Any vehicle is improperly parked in a disabled space;

(e) Any vehicle is blocking traffic, another vehicle, any door or fire exit, access to any trash container, fire lane, crosswalk, driveway, or it poses any other safety hazard (may also be cited for blocking traffic);

(f) Any vehicle is determined to be abandoned on University property.

(14) Vehicles in timed parking areas may be cited when their time parked exceeds the posted time limit. The vehicle may be cited again after double the posted time limit is exceeded.

EXAMPLE: In a 30-minute parking area, a vehicle may be cited after 30 minutes; again after a total of 90 minutes (including the first 30 minutes); again after 150 minutes and so forth. Timed parking is defined as "limited duration" meaning one-time parking per timed lot during a 24-hour period. Re-parking in the same lot constitutes continuous parking and the vehicle will be cited.

(15) Vehicles parked in permit-required parking areas may be cited every eight hours, not to exceed three citations every 24 hours.

(16) Other violations not defined by 1-15 above. $50

(17) Depositing litter or debris on a University parking lot, roadway or bikeway. $50 (This includes discarding parking citations/envelopes on the ground).

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 352.360
Hist.: SOSC 5, f. & ef. 9-2-76; SOSC 4-1979, f. 8-8-79, ef. 9-1-79; SOSC 5-1980, f. & ef. 8-19-80; SOSC 4-1982, f. & ef. 7-28-82; SOSC 6-1983, f. & ef. 8-23-83; SOSC 2-1984, f. & ef. 8-14-84; SOSC 8-1985, f. & ef. 8-12-85; SOSC 3-1986, f. & ef. 7-22-86; SOSC 5-1987, f. & ef. 9-8-87; SOSC 4-1989, f. & cert. ef. 9-19-89; SOSC 3-1990, f. & cert. ef. 5-31-90; SOSC 4-1991, f. & cert. ef. 6-11-91; SOSC 2-1994, f. & cert. ef. 6- 10-94; SOSC 2-1996, f. & cert. ef. 8-2-96; SOU 2-1997, f. & cert. ef. 8-26-97; SOU 2-1998, f. & cert. ef. 7-16-98; SOU 1-1999, f. & cert. ef. 5-7-99; SOU 1-2001, f. & cert. ef. 4-4-01; SOU 2-2002, f. & cert. ef. 6-28-02; SOU 1-2004, f. & cert. ef. 4-5-04; SOU 3-2006, f. & cert. ef. 6-29-06; SOU 3-2007, f. & cert. ef. 7-23-07; SOU 3-2009, f. 10-1-09, cert. ef. 10-4-09; SOU 2-2011, f. & cert. ef. 6-13-11; SOU 3-2013, f. & cert. ef. 6-20-13; SOU 15-2016, f. & cert. ef. 12-6-16

573-050-0045
Enforcement and Appeals

(1) Campus regulations are in effect 24 hours a day, seven days a week. Including summer term and holidays. Except when parking permits are not required (as stated in OAR 573-050-0030).

(2) Tow-away zones will be enforced 24 hours a day, seven days a week.

(3) All penalties prescribed in OAR 573-050-0040 will be administratively enforced by Southern Oregon University. Violators will receive a parking citation of offense, together with the scheduled fine for said violation, in accordance with the penalties set forth in OAR 573-050-0040.

(4) After receipt of a parking citation, the individual must, within fifteen calendar days of the date of the citation, file a request for a hearing before the CPS/Parking director or pay the appropriate fine. First appeals will be reviewed monthly by the CPS/Parking director; or by another CPS representative that the director appoints in his absence. Second appeals will be reviewed by the TPPC board. Appellants may appear in person to speak on their behalf at both first and second appeals. Only the President or Vice President of Finance and Administration has the authority to overrule a second appeal decision.

(5) Any University personnel or students issuing a Guest permit may contact Parking Services (at the Enrollment Services Center in Britt Hall) to transfer responsibility for citations received by their guests to themselves. This in no way implies the fine will be suspended, only that the guest will not be billed or pursued to pay the fine. The University personnel or students will be responsible and have all avenues of appeal available as if the citation were issued to them personally.

(6) Any person wishing to take a case before the CPS/Parking director must prepare a Petition for Appeal of Traffic Violation for a hearing indicating why the citation should be adjudicated. The petition form, available from Parking Services, must be completed online and submitted to parking services within fifteen calendar days of the citation date.

(7) A person appealing the citation may appear before the CPS/Parking Director to present his/her case. If the appellant does not wish to appear in person, for reasons he/she may specify, the written appeal will be reviewed by the CPS/Parking Director, which shall render judgment. The appellant shall be notified by mail or email of the decision of the CPS/Parking Director.

(8) The party appealing the citation may have legal counsel to present his/her case at both the first and second appeal hearings.

(9) In adjudicating appeals, the CPS/Parking Director shall have full authority to do the following:

(a) Dismiss the violations;

(b) Find the individual not guilty of the charges of the citation;

(c) Find the individual guilty of the violation and either impose a lesser fine, or apply an administration fee of $10.

(d) Enter a finding of guilty without imposing any fine; issue a reprimand or warning; or impose a fine.

(10) The decision of the CPS/Parking Director may be appealed a second and final time to the Transportation Planning and Parking Committee (TPPC) by appealing the citation online within ten calendar days following the decision of the CPS/Parking Director. Parking Services will also have an opportunity to submit a written statement concerning the issuance of the citation.

(11) Once the CPS/Parking Director makes the decision on an appeal for a parking citation, the appellant will have ten calendar days from the decision date to appeal the Director's decision further via the TPPC. After a decision has been made on the second appeal, the appellant has ten calendar days to pay any amount owed before it is charged to his/her account.

(12) The student's right to register for classes may be denied if any fines owing under these regulations remain unpaid.

(13) A student who fails to pay the University for any outstanding fine will have the fine charged to his/her account. Non-students who fail to pay any outstanding fines may be subjected to University collection policies and practices of up to and including assignment to an outside collection agency.

(14) Students leaving or graduating from the University will continue to be responsible for parking fines owed to the University, as long as such fines can be identified as belonging to the student(s) responsible.

(15) A faculty or staff member who fails to pay the University for any outstanding parking fines may have the fine deducted from his/her payroll check 30 days after written notice of the outstanding fines.

(16) Vehicles having outstanding parking fines may be denied issuance of a replacement or new parking decal.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 352.360
Hist.: SOSC 5, f. & ef. 9-2-76; SOSC 4-1979, f. 8-8-79, ef. 9-1-79; SOSC 5-1980, f. & ef. 8-19-80; SOSC 3-1981, f. & ef. 9-9-81; SOSC 4-1982, f. & ef. 7-28-82; SOSC 6-1983, f. & ef. 8-23-83; SOSC 2-1984, f. & ef. 8-14-84; SOSC 8-1985, f. & ef. 8-12-85; SOSC 3-1986, f. & ef. 7-22-86; SOSC 5-1987, f. & ef. 9-8-87; SOSC 4-1989, f. & cert. ef. 9-19-89; SOSC 3-1990, f. & cert. ef. 5-31-90; SOSC 4-1991, f. & cert. ef. 6-11-91; SOSC 3-1993, f. & cert. ef. 5-21-93; SOSC 2-1996, f. & cert. ef. 8-2-96; SOU 2-1997, f. & cert. ef. 8-26-97; SOU 2-1998, f. & cert. ef. 7-16-98; SOU 1-1999, f. & cert. ef. 5-7-99; SOU 2-2000, f. & cert. ef. 6-9-00; SOU 1-2001, f. & cert. ef. 4-4-01; SOU 2-2002, f. & cert. ef. 6-28-02; SOU 1-2004, f. & cert. ef. 4-5-04; SOU 1-2005, f. & cert. ef. 4-11-05; SOU 3-2006, f. & cert. ef. 6-29-06; SOU 3-2007, f. & cert. ef. 7-23-07; SOU 5-2008, f. 6-4-08, cert. ef. 6-5-08; SOU 3-2009, f. 10-1-09, cert. ef. 10-4-09; SOU 3-2010, f. & cert. ef. 6-8-10; SOU 2-2016, f. & cert. ef. 5-4-16; SOU 15-2016, f. & cert. ef. 12-6-16

Veterinary Medical Examining Board
Chapter 875

Rule Caption: Limits administration of rabies vaccine to licensees or other authorized persons.
Adm. Order No.: VMEB 3-2016(Temp)
Filed with Sec. of State: 12-12-2016
Certified to be Effective: 12-12-16 thru 6-9-17
Notice Publication Date:
Rules Amended: 875-015-0030
Subject: Rabies vaccine shall be administered only by an Oregon-licensed veterinarian, an Oregon-licensed Certified Veterinary Technician under direct supervision of an Oregon-licensed veterinarian, or a person authorized by the Oregon Public Health Veterinarian pursuant to OAR 333-019-0017.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-015-0030
Minimum Veterinary Practice Standards

Each veterinary medical facility shall comply with the following:

(1) Medical Records: A legible individual record shall be maintained for each animal. However, the medical record for a litter may be recorded either on the dam's record or on a litter record until the individual animals are permanently placed or reach the age of three months. Records for herd or flock animals may be maintained on a group or client basis. All records shall be readily retrievable and must be kept for a minimum of three (3) years following the last treatment or examination. Records shall include, but are not limited to, the following information:

(a) Name or initials of the veterinarian responsible for entries; any written entry to a medical record that is made subsequent to the date of treatment or service must include the date that the entry was added.

(b) Name, address and telephone number of the owner and/or client;

(c) Name, number or other identification of the animal and/or herd or flock;

(d) Species, breed, age, sex, and color or distinctive markings, where applicable, each individual animal;

(e) Vaccination history, if known, shall be part of the medical record;

(f) Beginning and ending dates of custody of the animal;

(g) Pertinent history and presenting complaint;

(h) A physical exam shall be performed to establish or maintain a VCPR; and then each time an animal is presented with a new health problem, unless the animal's temperament precludes examination, or physical exam is declined by the owner. For each physical exam the following conditions shall be evaluated and findings documented when applicable by species, even if such condition is normal:

(A) Temperature;

(B) Current weight or weight estimate for large animals;

(C) Body condition or score;

(D) Eyes, ears, nose and throat;

(E) Oral cavity;

(F) Cardiovascular and respiratory systems including heart rate and pulse, auscultation of the thorax, trachea, as species appropriate, and respiratory rate;

(G) Evaluation of the abdomen by palpation and/or auscultation if applicable by species;

(H) Lymph nodes;

(I) Musculoskeletal system;

(J) Neurological system;

(K) Genito/urinary system;

(L) Integumentary system

(M) All data obtained by instrumentation;

(N) Diagnostic assessment;

(O) If relevant, a prognosis of the animal's condition;

(P) Diagnosis or tentative diagnosis at the beginning of custody of animal;

(Q) Treatments and intended treatment plan, medications, immunizations administered, dosages, frequency and route of administration;

(R) All prescription or legend drugs dispensed, ordered or prescribed shall be recorded including: dosage, frequency, quantity and directions for use. Any changes made by telecommunications shall be recorded. Legend drugs in original unopened manufacturer's packaging dispensed or ordered for herd use are exempt from this rule. Legend and prescription drugs are as defined by the U.S. Food and Drug Administration in 'FDA and the Veterinarian'.

(S) Surgical procedures shall be described including name of the surgeon, suture material used, and diagnostic findings;

(T) Progress of the case while in the veterinary medical facility;

(U) Exposed radiographs shall have permanent facility and animal identification;

(V) If a client waives or declines any examinations, tests, or other recommended treatments, such waiver or denial shall be noted in the records.

(2) Surgery: Surgery shall be performed in a manner compatible with current veterinary practice with regard to anesthesia, asepsis or antisepsis, life support and monitoring procedures, and recovery care. The minimum standards for surgery shall be:

(a) Aseptic surgery shall be performed in a room or area designated for that purpose and isolated from other activities during the procedure. A separate, designated area is not necessarily required for herd or flock animal surgery or antiseptic surgery;

(b) The surgery room or area shall be clean, orderly, well-lighted and maintained in a sanitary condition;

(c) All appropriate equipment shall be sterilized:

(A) Chemical disinfection ("cold sterilization") shall be used only for field conditions or antiseptic surgical procedures;

(B) Provisions for sterilization shall include a steam pressure sterilizer (autoclave) or gas sterilizer (e.g., ethylene oxide) or equivalent.

(d) For each aseptic surgical procedure, a separate sterile surgical pack shall be used for each animal. Surgeons and surgical assistants shall use aseptic technique throughout the entire surgical procedure;

(e) Minor surgical procedures shall be performed at least under antiseptic surgical techniques;

(f) All animals shall be prepared for surgery as follows:

(A) Clip and surgically prepare the surgical area for aseptic surgical procedures;

(B) Loose hair must be removed from the surgical area;

(C) Scrub the surgical area with appropriate surgical soap;

(D) Disinfect the surgical area;

(E) Drape the surgical area appropriately.

(3) A veterinarian shall use appropriate and humane methods of anesthesia, analgesia and sedation to minimize pain and distress during any procedures or conditions and shall comply with the following standards:

(a) Animals shall have a documented physical exam conducted within 24 hours prior to the administration of a sedative or anesthetic, which is necessary for veterinary procedures, unless the temperament of the patient precludes an exam prior to the use of chemical restraint;

(b) An animal under general anesthesia for a medical or surgical procedure shall be under direct observation throughout the anesthetic period and during recovery from anesthesia until the patient is awake and in sternal recumbency;

(c) A method of cardiac monitoring shall be employed to assess heart rate and rhythm repeatedly during anesthesia and may include a stethoscope or electronic monitor;

(d) A method of monitoring the respiratory system shall be employed to assess respiratory rate and pattern repeatedly during anesthesia and may include a stethoscope or electronic monitor.

(e) Where general anesthesia is performed in a hospital or clinic for companion animal species (excluding farm animals), anesthetic equipment available shall include an oxygen source, equipment to maintain an open airway and a stethoscope;

(f) Anesthetic and sedation procedures and anesthetic and sedative medications used shall be documented, including agent used, dosage, route of administration, and strength, if available in more than one strength;

(g) Adequate means for resuscitation including intravenous catheter and fluids shall be available;

(h) Emergency drugs shall be immediately available at all times;

(i) While under sedation or general anesthesia, materials shall be provided to help prevent loss of body heat;

(j) Analgesic medications, techniques and/or husbandry methods shall be used to prevent and minimize pain in animals experiencing or expected to experience pain, including but not limited to all surgical procedures;

(k) Chemical restraint may be used in conjunction with, but not in lieu of, analgesic therapy;

(l) Appropriate analgesic therapy shall be guided by information specific to each case, including but not limited to species, breed, patient health and behavioral characteristics, the procedure performed, and the expected degree and duration of pain;

(4) Library: A library of appropriate and current veterinary journals and textbooks or access to veterinary internet resources shall be available for ready reference.

(5) Laboratory: Veterinarians shall have the capability for use of either in-house or outside laboratory service for appropriate diagnostic testing of animal samples.

(6) Biologicals and drugs: The minimum standards for drug procedures shall be:

(a) All biological substances shall be stored, maintained, administered, dispensed and prescribed in compliance with federal and state laws and manufacturers' recommendations;

(b) Controlled substances and legend drugs shall be dispensed, ordered or prescribed based on a VCPR and shall be labeled with the following:

(A) Name of client and identification of animal(s);

(B) Date dispensed;

(C) Complete directions for use;

(D) Name, strength, dosage and the amount of the drug dispensed;

(E) Manufacturer's expiration date;

(F) Name of prescribing veterinarian and veterinary medical facility.

(c) No biological or drug shall be administered or dispensed after the expiration date, for a fee.

(d) Rabies vaccine shall be administered only by an Oregon-licensed veterinarian, a Certified Veterinary Technician under direct supervision of an Oregon-licensed veterinarian, or a person authorized by the Oregon Public Health Veterinarian pursuant to OAR 333-019-0017.

(e) If requested, a prescription shall be provided to a client for medications prescribed by the veterinarian under a valid VCPR.

(7) A veterinarian shall not use, or participate in the use of, any form of advertising or solicitation which contains a false, deceptive or misleading statement or claim:

(a) Specialty Services: Veterinarians shall not make a statement or claim as a specialist or specialty practice unless the veterinarian is a diplomate of a recognized specialty organization of the American Veterinary Medical Association;

(b) The public shall be informed if an animal will be left unattended in the veterinary facility.

(8) The veterinarian shall be readily available or has arranged for emergency coverage or follow-up evaluation in the event of adverse reaction or the failure of the treatment regimen.

(9) Euthanasia: Documented consent shall be obtained and a physical exam conducted prior to performing euthanasia. The exam may be limited to the elements necessary for the humane application of the procedure, such as a weight estimate and visual assessment if necessary due to the patient's condition or temperament. When ownership and identification of an animal cannot be reasonably established, the medical record for euthanasia shall contain a physical description of the animal.

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.040 & 686.370
Hist.: VME 5-1992, f. & cert. ef. 12-10-92; VMEB 1-2006, f. & cert. ef. 2-8-06; VMEB 2-2006, f. & cert. ef. 5-11-06; VMEB 1-2008, f. & cert. ef. 2-11-08; VMEB 2-2010, f. & cert. ef. 5-6-10; VMEB 4-2011, f. & cert. ef. 8-5-11; VMEB 2-2014, f. & cert. ef. 1-17-14; VMEB 3-2016(Temp), f. & cert. ef. 12-12-16 thru 6-9-17

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Rule Caption: Prohibits administration of rabies vaccine by veterinary student interns.
Adm. Order No.: VMEB 4-2016(Temp)
Filed with Sec. of State: 12-12-2016
Certified to be Effective: 12-12-16 thru 6-9-17
Notice Publication Date:
Rules Amended: 875-010-0045
Subject: Prohibits administration of rabies vaccine by veterinary student interns.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-010-0045
Student Interns

(1) Any person wishing to work in Oregon as a student intern may do so if he or she is engaged in a student intern program administered by a veterinary college or university, or a veterinary technology program, approved by the Board or the American Veterinary Medical Association.

(2) Supervision of student interns. All acts which a student intern may perform must be under the direct supervision of a licensed veterinarian. "Direct supervision" means that each act shall be performed by the student intern only after receiving specific directions from and in the presence of an Oregon licensed veterinarian. Certified Veterinary Technician student interns may work under direct supervision of a licensed veterinarian or Certified Veterinary Technician.

(3) Veterinary student interns may perform the following acts:

(a) Obtaining and Recording Information. Student interns may obtain and record the following information:

(A) Complete admission records, including recording the statements made by the client concerning the patient's problems and history. Student interns may also record their own observations of the patient. However, student interns cannot state or record their opinion concerning diagnosis of the patient;

(B) Maintain daily progress records, surgery logs, X-ray logs, Drug Enforcement Agency logs, and all other routine records as directed by the supervising veterinarian.

(b) Perform surgery, if relevant coursework has been successfully completed, and if determined by the supervising veterinarian to be competent in basic surgical techniques;

(c) Preparation of patients, instruments, equipment, and medicants for surgery. Student interns may:

(A) Prepare and sterilize surgical packs;

(B) Clip, surgically scrub, and disinfect the surgical site in preparation for surgery;

(C) Administer preanesthetic drugs as prescribed by the supervising veterinarian;

(D) Position the patient for anesthesia;

(E) Administer anesthesia as prescribed by the supervising veterinarian;

(F) Operate anesthetic machines, oxygen equipment, and monitoring equipment.

(d) Collection of specimens and performance of laboratory procedures. Preceptees and Student Interns may:

(A) Collect urine, feces, sputum, and all other excretions for laboratory analysis;

(B) Collect blood samples for laboratory;

(C) Collect skin scrapings;

(D) Perform routine laboratory procedures including urinalysis, fecal analyses, hematological, and serological examinations.

(e) Assisting the veterinarian in diagnostic medical and surgical procedures. Student interns may assist supervising veterinarians in the following diagnostic, medical, and surgical proceedings:

(A) Take the patient's temperature, pulse and respiration;

(B) Medically bathe the patient;

(C) Administer topical, oral, hypodermic, and intravenous medication as directed by the supervising veterinarian;

(D) Operate diagnostic imaging equipment;

(E) Perform dental prophylaxis, including operating ultrasonic dental instruments.

(f) Student interns may perform other acts not specifically enumerated herein under the supervision of a veterinarian licensed to practice veterinary medicine in the State of Oregon.

(4) Certified Veterinary Technician student interns may perform all the acts enumerated in OAR 875-030-0040(2) and may not perform the acts prohibited in OAR 875-030-0040(3).

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.040(13)
Hist.: VE 7-1978, f. & ef. 7-10-78; VME 2-1994, f. & cert. ef. 11-30-94; VMEB 1-2006, f. & cert. ef. 2-8-06; VMEB 1-2010, f. & cert. ef. 5-6-10; VMEB 3-2014, f. & cert. ef. 1-17-14; VMEB 1-2016(Temp), f. & cert. ef. 8-4-16 thru 1-4-17; VMEB 4-2016(Temp), f. & cert. ef. 12-12-16 thru 6-9-17

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Rule Caption: Eliminates limits on veterinary facility management.
Adm. Order No.: VMEB 5-2016(Temp)
Filed with Sec. of State: 12-12-2016
Certified to be Effective: 12-12-16 thru 6-9-17
Notice Publication Date:
Rules Suspended: 875-010-0031
Subject: Eliminates limits on veterinary facility management.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-010-0031
Registration of Veterinary Facilities; Managing Veterinarian; Registration Denial, Suspension, Revocation; Inspection

(1) Each veterinary medical facility in Oregon as defined in 875-005-0005 must register with the Board and designate a Managing Veterinarian with the following exceptions:

(a) Any facilities owned and operated by a local, regional, state or federal government agency

(b) Facilities where privately owned animals are housed and where mobile veterinarians or mobile veterinary clinics may routinely come to

provide veterinary services, e.g., private barn, home, boarding stable or animal event location

(c) Locations where animals are undergoing a medical crisis and conditions preclude transport to a veterinary facility (accident site)

(d) Temporary facilities established under a declared emergency

(e) Teaching facilities as established by AVMA-accredited schools of veterinary science or veterinary technology.

(2) Requirements for registered Veterinary Facilities

(a) Each facility registration expires on December 31st or upon a change in facility ownership.

(b) Each facility identified by a separate physical address will be considered a separate facility requiring registration.

(c) Mobile facilities, unless operated as a satellite of a registered fixed facility, will require individual registration.

(d) Temporary facilities, providing only spay/neuter, vaccinations, micro-chipping and examinations may operate up to 15 days per year at any one location under the registration of an Oregon fixed-location facility and under the oversight of the fixed-location's Managing Veterinarian, unless otherwise approved by the Board.

(3) Requirements for the Managing Veterinarian.

(a) Provide the Board with documented authority from the facility owner to maintain the facility within the standards set forth by this chapter.

(b) Ensure facilities maintain and post a valid facility registration issued by the Board.

(c) Ensure timely provision of medical record copies from the facility when requested.

(d) A veterinary intern (OAR 875-010-0026) may not be designated as Managing Veterinarian.

(e) A licensee with a relevant disciplinary history or who has been or currently is under a disciplinary order of the Board may be denied designation as Managing Veterinarian.

(f) No one veterinarian may act as the Managing Veterinarian for more than four separate facilities at any one time. If designated as Managing Veterinarian for more than two separate facilities, none of the facilities may be more than 100 miles apart.

(g) The Managing Veterinarian must be physically present at each of their facilities at least five days out of any thirty-day period and be available to provide continuous oversight to all facilities.

(4) Procedures for any change in the Managing Veterinarian. The Managing Veterinarian on record with the Board as responsible for a facility remains responsible for that facility until one of the following occurs:

(a) The Board is notified in writing of a new Managing Veterinarian that has accepted responsibility.

(b) The Board is notified in writing that the Managing Veterinarian wishes to be relieved of the position and associated responsibilities.

(c) The Managing Veterinarian is incapacitated to the extent that they cannot provide oversight of any facility.

(5) Applicants for facility registration must complete an application form available from the Board.

(6) A completed application will include payment of $150 registration fee, inspector's or self-certification of compliance with minimum standards of OAR 875-015-0020 and 875-015-0030, and designation of a Managing Veterinarian as defined in 875-015-0065.

(7) Denial of Facility Registration Application. The Board may deny an application for facility registration or renewal if:

(a) The application is incomplete or the registration fee is not submitted.

(b) The facility fails to meet minimum standards or fails to correct deficiencies within an appropriate time frame following inspection.

(c) The designated Managing Veterinarian fails meet the minimum facility standards listed in OAR 875-015-0020 and OAR 875-015-0030.

(d) No Managing Veterinarian, meeting all requirements of this chapter, has been designated.

(8) Suspension or Revocation of a Facility Registration. The Board may withhold, suspend or revoke a facility registration if:

(a) No Managing Veterinarian is designated for the facility for more than 15 consecutive days. An interim Managing Veterinarian may be designated for a period not to exceed 30 days total.

(b) When it has been determined by the Board that the managing Veterinarian has failed to meet all the minimum facility standards as provided for in the rules of this act.

(c) Investigation or inspection has revealed unresolved public health and safety risks or other conditions noncompliant with OAR 875-015-0020 and OAR 875-015-0030.

(9) All Facility Registrations terminate upon a change in the facility owner.

(10) Inspection of Facilities: The purpose of inspection is to ensure that public health and safely is maintained by meeting the minimum facility standards listed in OAR 875-015-0020 and 875-015-0030. The Board may designate or employ qualified persons to do the inspections and may delegate inspections to other state or federal agency regulators. Prior to January 2017 the Board may accept self-certification of compliance by the Managing Veterinarian in-lieu-of inspection. This self-certification shall be submitted using a form provided by the Board.

(a) The Board may inspect each veterinary facility:

(A) Before a new facility receives an initial facility registration

(B) Periodically, at least once every three years

(b) The board may inspect any veterinary facility:

(A) At any time upon receipt of a complaint or if it has cause to believe the facility is noncompliant with OAR 875-015-0020 or 875-015-0030.

(B) Upon a change in ownership or a change in the Managing Veterinarian

(C) As follow-up at any time after an inspection has found non-compliant conditions.

(c) Initial and periodic facility inspections may be waived for facilities holding a current American Animal Hospital Association (AHAA) certification.

(d) Inspections may be documented in writing and by audio, video and still picture recording.

(e) Upon an inspection finding of non-compliance with OAR 875-015-0020 or 875-015-0030, the Board or its representative may do any or all of the following:

(A) Establish a reasonable time line for bringing the facility into compliance

(B) Issue a civil penalty or citation

(C) Restrict facility operations when the failure to meet minimum facility standards poses an unresolved risk to public health and safety or other conditions noncompliant with OAR 875-015-0020 or 875-015-0030.

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.130
Hist.: VMEB 1-2015, f. & cert. ef. 11-13-15; Suspended by VMEB 5-2016(Temp), f. & cert. ef. 12-12-16 thru 6-9-17

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Rule Caption: Requires CE in pain management and antibiotic prescribing.
Adm. Order No.: VMEB 6-2016
Filed with Sec. of State: 12-12-2016
Certified to be Effective: 12-12-16
Notice Publication Date: 8-1-2016
Rules Amended: 875-010-0090
Subject: Requires veterinarians to obtain Continuing Education of one hour each in judicious antibiotic use and appropriate analgesic and anesthetic
methods.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-010-0090
Continuing Education Requirements (CE)

(1) All active licensees, including veterinarians and certified veterinary technicians, must comply with the CE provided in this rule in order to renew their licenses.

(2) Licensees wishing to renew their license must complete the minimum required number of CE hours every two years. Veterinarians shall report 30 hours of CE to the Board with license renewals for every odd-numbered year. Certified veterinary technicians shall report 15 hours of CE to the Board for every even-numbered year. The required hours may be obtained online and be satisfied with any combination of the following continuing education activities:

(a) Attendance at scientific workshops or seminars approved by the Board or by the American Association of Veterinary Boards Registry of Approved Continuing Education (RACE).

(b) A maximum of four hours for veterinarians or two hours for certified veterinary technicians reading approved scientific journals. One subscription to an approved journal is equal to one hour of credit.

(c) A maximum of six hours for veterinarians or three hours for certified veterinary technicians of workshops or seminars on non-scientific subjects relating to the practice of veterinary medicine such as communication skills, practice management, stress management, or chemical impairment.

(d) A minimum for veterinarians of one hour each in judicious antibiotic use and appropriate analgesic and anesthetic methods.

(3) Workshops, seminars, and prepared materials on scientific and non-scientific subjects relating to veterinary medicine sponsored by the following organizations are approved:

(a) American Veterinary Medical Association (AVMA) and Canadian Veterinary Medical Association (CVMA);

(b) Specialty and allied groups of the American Veterinary Medical Association and Canadian Veterinary Medical Association;

(c) Regional meetings such as the Inter-Mountain Veterinary Medical Association, Central Veterinary Conference, and Western Veterinary Conference;

(d) Any state or province veterinary medical association;

(e) Any local or regional veterinary medical association;

(f) The American Animal Hospital Association;

(g) American and Canadian Veterinary Schools accredited by the American Veterinary Medical Association;

(h) All federal, state or regional veterinary medical academies or centers;

(i) Other programs receiving prior approval by the Board;

(j) The Board may approve other sponsors for lectures or prepared materials upon written request by the attending veterinarian or the sponsor.

(4) Scientific journals and publications relating to veterinary medicine are approved by the Board to satisfy a maximum of four hours of non-lecture CE activities.

(5) Study in a graduate resident program at an AVMA-approved veterinary school will satisfy the CE requirements for the year in which the veterinarian is enrolled in such program.

(6) Postgraduate coursework in veterinary science or veterinary public health at an AVMA, or Board-approved educational institution will satisfy CE requirements on a semester or credit hour basis for the reporting period in which the coursework occurs.

(7) Reporting CE credits.

(a) At the time of making application for license renewal in years when CE reporting is required, the veterinarian shall certify on the application form that 30 hours of CE, and the veterinary technician shall certify on the application form that 15 hours of CE, as set forth in this rule have been satisfied. Proof of participation in such CE programs must be kept by the licensee for a period of at least two years, and the licensee must permit the Board to inspect CE records. Failure to keep or provide these records to the Board shall constitute grounds for non-renewal of the license, or, if the license has been issued for that year, for revocation of the license;

(b) Proof of compliance with the CE requirement of this rule may be supplied through registration forms at lectures, certificates issued by the sponsors of lectures, subscriptions to journals, and other documentation approved by the Board.

(8) The Board may approve CE programs presented by non-veterinarians, if program content is pertinent or complementary to veterinary medicine.

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.410 - 686.420
Hist.: VMEB 1-2006, f. & cert. ef. 2-8-06; VMEB 2-2006, f. & cert. ef. 5-11-06; VMEB 1-2008, f. & cert. ef. 2-11-08; VMEB 2-2008(Temp), f. & cert. ef. 2-11-08 thru 8-9-08; Administrative correction 8-21-08; VMEB 13-2008, f. & cert. ef. 12-15-08; VMEB 1-2009, f. & cert. ef. 4-20-09; VMEB 2-2013, f. & cert. ef. 10-29-13; VMEB 3-2014, f. & cert. ef. 1-17-14; VMEB 6-2016, f. & cert. ef. 12-12-16

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Rule Caption: Corrects omission in practice limitations for persons not licensed as Certified Veterinary Technicians.
Adm. Order No.: VMEB 7-2016
Filed with Sec. of State: 12-13-2016
Certified to be Effective: 12-13-16
Notice Publication Date: 8-1-2016
Rules Amended: 875-030-0050
Subject: Prohibits work under indirect supervision for persons not licensed as Certified Veterinary Technicians.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-030-0050
Practice Limitations for Individuals not Certified as Veterinary Technicians

(1) Persons who are not licensed by this Board as CVTs may, under the supervision of a licensed veterinarian, perform all acts that a CVT may perform except:

(2) Induce anesthesia, except to place an endotracheal tube to establish an airway in emergencies (OAR 875-030-0040(2)(b)(E);

(3) Operate X-ray equipment unless the person has completed 20 hours training in radiograph safety (2)(b)(G) as required by the Oregon State Health Division (OAR 333);

(4) Perform dental extractions (2)(e)(G);

(5) Administer rabies vaccine (2)(e)(H); and

(6) Inject or implant a permanent identification device (875-030-0040(l)).

(7) Perform any duties under indirect supervision as defined in OAR 875-005-0005(13)(c).

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.350 - 686.370
Hist.: VE 5, f. & ef. 8-3-76; VME 3-1983, f. & ef. 1-21-83; VME 2-1989, f. 8-29-89, cert. ef. 10-1-89; VME 1-1991, f. & cert. ef. 1-24-91; VME 3-1991, f. & cert. ef. 12-9-91; VME 3-1992, f. & cert. ef. 10-9-92, Renumbered from 875-010-0025; VMEB 1-2002(Temp), f. & cert. ef. 4-23-02 thru 10-20-02; Administrative correction 12-2-02; VMEB 1-2008, f. & cert. ef. 2-11-08; VMEB 5-2008, f. & cert. ef. 5-12-08; VMEB 12-2008, f. & cert. ef. 7-22-08; VMEB 16-2008, f. & cert. ef. 12-15-08; VMEB 4-2014, f. & cert. ef. 1-17-14; VMEB 2-2016(Temp), f. & cert. ef. 8-4-16 thru 1-4-17; VMEB 7-2016, f. & cert. ef. 12-13-16

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Rule Caption: Corrects citation in rule governing CVT student interns' work in veterinary practices.
Adm. Order No.: VMEB 8-2016
Filed with Sec. of State: 12-13-2016
Certified to be Effective: 12-13-16
Notice Publication Date: 8-1-2016
Rules Amended: 875-010-0045
Subject: Corrects inaccurate citation referencing CVT student interns' work in veterinary practices. Permits CVT student interns to perform all work allowed of licensed CVTs.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-010-0045
Student Interns

(1) Any person wishing to work in Oregon as a student intern may do so if he or she is engaged in a student intern program administered by a veterinary college or university, or a veterinary technology program, approved by the Board or the American Veterinary Medical Association.

(2) Supervision of student interns. All acts which a student intern may perform must be under the direct supervision of a licensed veterinarian. "Direct supervision" means that each act shall be performed by the student intern only after receiving specific directions from and in the presence of an Oregon licensed veterinarian. Certified Veterinary Technician student interns may work under direct supervision of a licensed veterinarian or Certified Veterinary Technician.

(3) Veterinary student interns may perform the following acts:

(a) Obtaining and Recording Information. Student interns may obtain and record the following information:

(A) Complete admission records, including recording the statements made by the client concerning the patient's problems and history. Student interns may also record their own observations of the patient. However, student interns cannot state or record their opinion concerning diagnosis of the patient;

(B) Maintain daily progress records, surgery logs, X-ray logs, Drug Enforcement Agency logs, and all other routine records as directed by the supervising veterinarian.

(b) Perform surgery, if relevant coursework has been successfully completed, and if determined by the supervising veterinarian to be competent in basic surgical techniques;

(c) Preparation of patients, instruments, equipment, and medicants for surgery. Student interns may:

(A) Prepare and sterilize surgical packs;

(B) Clip, surgically scrub, and disinfect the surgical site in preparation for surgery;

(C) Administer preanesthetic drugs as prescribed by the supervising veterinarian;

(D) Position the patient for anesthesia;

(E) Administer anesthesia as prescribed by the supervising veterinarian;

(F) Operate anesthetic machines, oxygen equipment, and monitoring equipment.

(d) Collection of specimens and performance of laboratory procedures. Preceptees and Student Interns may:

(A) Collect urine, feces, sputum, and all other excretions for laboratory analysis;

(B) Collect blood samples for laboratory;

(C) Collect skin scrapings;

(D) Perform routine laboratory procedures including urinalysis, fecal analyses, hematological, and serological examinations.

(e) Assisting the veterinarian in diagnostic medical and surgical procedures. Student interns may assist supervising veterinarians in the following diagnostic, medical, and surgical proceedings:

(A) Take the patient's temperature, pulse and respiration;

(B) Medically bathe the patient;

(C) Administer topical, oral, hypodermic, and intravenous medication as directed by the supervising veterinarian;

(D) Operate diagnostic imaging equipment;

(E) Perform dental prophylaxis, including operating ultrasonic dental instruments.

(f) Student interns may perform other acts not specifically enumerated herein under the supervision of a veterinarian licensed to practice veterinary medicine in the State of Oregon, however, under no circumstances may a student intern administer rabies vaccine.

(4) Certified Veterinary Technician student interns may perform all the acts enumerated in OAR 875-030-0040(2) and may not perform the acts prohibited in 875-030-0040(3).

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.040(13)
Hist.: VE 7-1978, f. & ef. 7-10-78; VME 2-1994, f. & cert. ef. 11-30-94; VMEB 1-2006, f. & cert. ef. 2-8-06; VMEB 1-2010, f. & cert. ef. 5-6-10; VMEB 3-2014, f. & cert. ef. 1-17-14; VMEB 1-2016(Temp), f. & cert. ef. 8-4-16 thru 1-4-17; VMEB 4-2016(Temp), f. & cert. ef. 12-12-16 thru 6-9-17; VMEB 8-2016, f. & cert. ef. 12-13-16

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Rule Caption: Reduces and clarifies experience requirements for out-of-state applicants for Certified Veterinary Technician licensure.
Adm. Order No.: VMEB 9-2016
Filed with Sec. of State: 12-13-2016
Certified to be Effective: 12-13-16
Notice Publication Date: 8-1-2016
Rules Amended: 875-030-0010
Subject: Reduces and clarifies CVT license eligibility requirements for out-of-state applicants.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-030-0010
Criteria for Becoming a Certified Veterinary Technician (CVT)

In order to be licensed as a CVT, an individual must:

(1) Pass the examinations referred to in OAR 875-030-0020; and

(2) Hold a certificate in veterinary technology (or a comparable certificate) from a college accredited by the American Veterinary Medical Association, or other program approved by the Board; or

(3) Have been actively licensed or registered in good standing as a veterinary technician in another state or states for a period of at least four years and:

(a) Have been employed as a licensed veterinary technician or instructor of veterinary technology performing duties substantially equivalent to those in OAR 875-030-0040 for a minimum of four years; and

(b) Pass the examinations referred to in OAR 87-030-0020; and

(c) Provide notarized letters confirming clinical competency as a veterinary technician or instructor from at least a veterinarian or college official who supervised the applicant pursuant to (a) of this section; and

(d) Provide W2 federal tax forms or other Board-approved proof of employment as a licensed veterinary technician or instructor; and

(e) Provide proof of CE as required in OAR 875-010-0090 that is current at the time of application.

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.350 - 686.370
Hist.: VE 5, f. & ef. 8-3-76; VME 3-1983, f. & ef. 1-21-83; VME 2-1989, f. 8-29-89, cert. ef. 10-1-89; VME 1-1991, f. & cert. ef. 1-24-91; VME 3-1991, f. & cert. ef. 12-9-91; VME 3-1992, f. & cert. ef. 10-9-92, Renumbered from 875-010-0025; VMEB 2-2000, f. & cert. ef. 6-21-00; VMEB 1-2006, f. & cert. ef. 2-8-06; VMEB 2-2006, f. & cert. ef. 5-11-06; VMEB 10-2008, f. & cert. ef. 7-22-08; VMEB 15-2008, f. & cert. ef. 12-15-08; VMEB 3-2009, f. & cert. ef. 10-15-09; VMEB 3-2010, f. & cert. ef. 5-6-10; VMEB 2-2011, f. & cert. ef. 3-2-11; VMEB 4-2014, f. & cert. ef. 1-17-14; VMEB 6-2014, f. & cert. ef. 10-20-14; VMEB 9-2016, f. & cert. ef. 12-13-16

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Rule Caption: Prohibits Certified Veterinary Technician student interns from administering rabies vaccine.
Adm. Order No.: VMEB 10-2016(Temp)
Filed with Sec. of State: 12-14-2016
Certified to be Effective: 12-14-16 thru 6-11-17
Notice Publication Date:
Rules Amended: 875-010-0045
Subject: Prohibits Certified Veterinary Technician student interns from administering rabies vaccine.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-010-0045
Student Interns

(1) Any person wishing to work in Oregon as a student intern may do so if he or she is engaged in a student intern program administered by a veterinary college or university, or a veterinary technology program, approved by the Board or the American Veterinary Medical Association.

(2) Supervision of student interns. All acts which a student intern may perform must be under the direct supervision of a licensed veterinarian. "Direct supervision" means that each act shall be performed by the student intern only after receiving specific directions from and in the presence of an Oregon licensed veterinarian. Certified Veterinary Technician student interns may work under direct supervision of a licensed veterinarian or Certified Veterinary Technician.

(3) Veterinary student interns may perform the following acts:

(a) Obtaining and Recording Information. Student interns may obtain and record the following information:

(A) Complete admission records, including recording the statements made by the client concerning the patient's problems and history. Student interns may also record their own observations of the patient. However, student interns cannot state or record their opinion concerning diagnosis of the patient;

(B) Maintain daily progress records, surgery logs, X-ray logs, Drug Enforcement Agency logs, and all other routine records as directed by the supervising veterinarian.

(b) Perform surgery, if relevant coursework has been successfully completed, and if determined by the supervising veterinarian to be competent in basic surgical techniques;

(c) Preparation of patients, instruments, equipment, and medicants for surgery. Student interns may:

(A) Prepare and sterilize surgical packs;

(B) Clip, surgically scrub, and disinfect the surgical site in preparation for surgery;

(C) Administer preanesthetic drugs as prescribed by the supervising veterinarian;

(D) Position the patient for anesthesia;

(E) Administer anesthesia as prescribed by the supervising veterinarian;

(F) Operate anesthetic machines, oxygen equipment, and monitoring equipment.

(d) Collection of specimens and performance of laboratory procedures. Preceptees and Student Interns may:

(A) Collect urine, feces, sputum, and all other excretions for laboratory analysis;

(B) Collect blood samples for laboratory;

(C) Collect skin scrapings;

(D) Perform routine laboratory procedures including urinalysis, fecal analyses, hematological, and serological examinations.

(e) Assisting the veterinarian in diagnostic medical and surgical procedures. Student interns may assist supervising veterinarians in the following diagnostic, medical, and surgical proceedings:

(A) Take the patient's temperature, pulse and respiration;

(B) Medically bathe the patient;

(C) Administer topical, oral, hypodermic, and intravenous medication as directed by the supervising veterinarian;

(D) Operate diagnostic imaging equipment;

(E) Perform dental prophylaxis, including operating ultrasonic dental instruments.

(f) Student interns may perform other acts not specifically enumerated herein under the supervision of a veterinarian licensed to practice veterinary medicine in the State of Oregon.

(4) Certified Veterinary Technician student interns may perform all the acts enumerated in OAR 875-030-0040(2) and may not perform the acts prohibited in 875-030-0040(3).

(a) Certified Veterinary Technician student interns may not administer rabies vaccine.

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.040(13)
Hist.: VE 7-1978, f. & ef. 7-10-78; VME 2-1994, f. & cert. ef. 11-30-94; VMEB 1-2006, f. & cert. ef. 2-8-06; VMEB 1-2010, f. & cert. ef. 5-6-10; VMEB 3-2014, f. & cert. ef. 1-17-14; VMEB 1-2016(Temp), f. & cert. ef. 8-4-16 thru 1-4-17; VMEB 4-2016(Temp), f. & cert. ef. 12-12-16 thru 6-9-17; VMEB 8-2016, f. & cert. ef. 12-13-16; VMEB 10-2016(Temp), f. & cert. ef. 12-14-16 thru 6-11-17

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309-019-0130	11-30-2016	Amend	1-1-2017
309-019-0135	11-30-2016	Amend	1-1-2017
309-019-0140	11-30-2016	Amend	1-1-2017
309-019-0145	11-30-2016	Amend	1-1-2017
309-019-0175	11-30-2016	Amend	1-1-2017
309-019-0195	11-30-2016	Amend	1-1-2017
309-019-0210	11-30-2016	Amend	1-1-2017
309-019-0215	11-30-2016	Amend	1-1-2017
309-019-0220	11-30-2016	Amend	1-1-2017
309-019-0225	11-30-2016	Adopt	1-1-2017
309-019-0230	11-30-2016	Adopt	1-1-2017
309-019-0235	11-30-2016	Adopt	1-1-2017
309-019-0240	11-30-2016	Adopt	1-1-2017
309-019-0245	11-30-2016	Adopt	1-1-2017
309-019-0248	11-30-2016	Adopt	1-1-2017
309-019-0250	11-30-2016	Adopt	1-1-2017
309-019-0255	11-30-2016	Adopt	1-1-2017
309-022-0100	12-1-2016	Amend	1-1-2017
309-022-0105	12-1-2016	Amend	1-1-2017
309-022-0135	12-1-2016	Amend	1-1-2017
309-022-0175	12-1-2016	Amend	1-1-2017
309-022-0205	12-1-2016	Amend	1-1-2017
309-027-0010	12-5-2016	Adopt	1-1-2017
309-027-0020	12-5-2016	Adopt	1-1-2017
309-027-0030	12-5-2016	Adopt	1-1-2017
309-027-0040	12-5-2016	Adopt	1-1-2017
309-027-0050	12-5-2016	Adopt	1-1-2017
309-027-0060	12-5-2016	Adopt	1-1-2017
309-032-0850	12-1-2016	Amend	1-1-2017
309-032-0860	12-1-2016	Amend	1-1-2017
309-032-0870	12-1-2016	Amend	1-1-2017

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309-039-0510	11-30-2016	Amend	1-1-2017
309-039-0530	11-30-2016	Amend	1-1-2017
309-039-0580	11-30-2016	Amend	1-1-2017
333-007-0010	11-28-2016	Amend	1-1-2017
333-007-0010(T)	11-28-2016	Repeal	1-1-2017
333-007-0090	11-28-2016	Amend	1-1-2017
333-007-0090	12-2-2016	Amend(T)	1-1-2017
333-007-0090	12-15-2016	Amend(T)	1-1-2017
333-007-0100	11-28-2016	Amend	1-1-2017
333-007-0100(T)	11-28-2016	Repeal	1-1-2017
333-007-0200	11-28-2016	Amend	1-1-2017
333-007-0210	11-28-2016	Amend	1-1-2017
333-007-0220	11-28-2016	Amend	1-1-2017
333-007-0300	11-28-2016	Amend	1-1-2017
333-007-0310	12-2-2016	Amend(T)	1-1-2017
333-007-0315	12-2-2016	Amend(T)	1-1-2017
333-007-0320	12-2-2016	Amend(T)	1-1-2017
333-007-0320	12-15-2016	Amend(T)	1-1-2017
333-007-0350	12-2-2016	Amend(T)	1-1-2017
333-007-0350	12-15-2016	Amend(T)	1-1-2017
333-007-0360	12-2-2016	Amend(T)	1-1-2017
333-007-0360	12-15-2016	Amend(T)	1-1-2017
333-007-0410	12-2-2016	Amend(T)	1-1-2017
333-007-0430	12-2-2016	Amend(T)	1-1-2017
333-007-0440	12-2-2016	Amend(T)	1-1-2017
333-007-0440	12-15-2016	Amend(T)	1-1-2017
333-007-0450	12-2-2016	Amend(T)	1-1-2017
333-007-0480	12-2-2016	Amend(T)	1-1-2017
333-007-0490	12-2-2016	Suspend	1-1-2017
333-008-0010	11-28-2016	Amend	1-1-2017
333-008-0023	11-28-2016	Amend	1-1-2017
333-008-0040	11-28-2016	Amend	1-1-2017
333-008-0600	11-28-2016	Amend	1-1-2017
333-008-1020	11-28-2016	Amend	1-1-2017
333-008-1110	11-28-2016	Amend	1-1-2017
333-008-1190	11-28-2016	Repeal	1-1-2017
333-008-1200	11-28-2016	Amend	1-1-2017
333-008-1200(T)	11-28-2016	Repeal	1-1-2017
333-008-1225	11-28-2016	Repeal	1-1-2017
333-008-1230	11-28-2016	Amend	1-1-2017
333-008-1230(T)	11-28-2016	Repeal	1-1-2017
333-008-1255	11-28-2016	Adopt	1-1-2017
333-008-1500	11-28-2016	Amend	1-1-2017
333-008-1500(T)	11-28-2016	Repeal	1-1-2017
333-008-1505	11-28-2016	Amend	1-1-2017
333-008-1505(T)	11-28-2016	Repeal	1-1-2017
333-008-1620	11-28-2016	Amend	1-1-2017
333-008-1730	11-28-2016	Amend	1-1-2017
333-008-1740	11-28-2016	Amend	1-1-2017
333-008-1740(T)	11-28-2016	Repeal	1-1-2017
333-008-1760	11-28-2016	Amend	1-1-2017
333-008-1770	11-28-2016	Amend	1-1-2017
333-008-1820	11-28-2016	Amend	1-1-2017
333-008-2080	11-28-2016	Amend	1-1-2017
333-008-2120	11-28-2016	Amend	1-1-2017
333-008-2130	11-28-2016	Repeal	1-1-2017
333-008-2190	11-28-2016	Amend	1-1-2017
333-008-9900	11-28-2016	Amend	1-1-2017
333-010-0405	12-12-2016	Amend	1-1-2017
333-010-0415	12-12-2016	Amend	1-1-2017
333-010-0435	12-12-2016	Amend	1-1-2017
333-016-2035	12-1-2016	Adopt	1-1-2017
333-016-2040	12-1-2016	Adopt	1-1-2017
333-016-2050	12-1-2016	Adopt	1-1-2017
333-016-2060	12-1-2016	Adopt	1-1-2017
333-016-2070	12-1-2016	Adopt	1-1-2017
333-016-2090	12-1-2016	Adopt	1-1-2017
333-028-0320	11-18-2016	Amend	1-1-2017
333-064-0100	12-2-2016	Amend(T)	1-1-2017
333-064-0100	12-15-2016	Amend(T)	1-1-2017
333-064-0110	12-2-2016	Amend(T)	1-1-2017
333-064-0110	12-15-2016	Amend(T)	1-1-2017
333-068-0005	1-1-2017	Repeal	1-1-2017
333-068-0010	1-1-2017	Repeal	1-1-2017
333-068-0015	1-1-2017	Repeal	1-1-2017
333-068-0020	1-1-2017	Repeal	1-1-2017
333-068-0025	1-1-2017	Repeal	1-1-2017
333-068-0030	1-1-2017	Repeal	1-1-2017
333-068-0035	1-1-2017	Repeal	1-1-2017
333-068-0040	1-1-2017	Repeal	1-1-2017
333-068-0045	1-1-2017	Repeal	1-1-2017
333-068-0050	1-1-2017	Repeal	1-1-2017
333-068-0055	1-1-2017	Repeal	1-1-2017
333-068-0060	1-1-2017	Repeal	1-1-2017
333-068-0065	1-1-2017	Repeal	1-1-2017
333-069-0005	1-1-2017	Repeal	1-1-2017
333-069-0010	1-1-2017	Repeal	1-1-2017
333-069-0015	1-1-2017	Repeal	1-1-2017
333-069-0020	1-1-2017	Repeal	1-1-2017
333-069-0030	1-1-2017	Repeal	1-1-2017
333-069-0040	1-1-2017	Repeal	1-1-2017
333-069-0050	1-1-2017	Repeal	1-1-2017
333-069-0060	1-1-2017	Repeal	1-1-2017
333-069-0070	1-1-2017	Repeal	1-1-2017
333-069-0080	1-1-2017	Repeal	1-1-2017
333-069-0085	1-1-2017	Am. & Ren.	1-1-2017
333-069-0090	1-1-2017	Repeal	1-1-2017
333-069-0100	1-1-2017	Adopt	1-1-2017
333-069-0120	1-1-2017	Adopt	1-1-2017
333-070-0075	1-1-2017	Repeal	1-1-2017
333-070-0080	1-1-2017	Repeal	1-1-2017
333-070-0085	1-1-2017	Repeal	1-1-2017
333-070-0090	1-1-2017	Repeal	1-1-2017
333-070-0095	1-1-2017	Repeal	1-1-2017
333-070-0100	1-1-2017	Repeal	1-1-2017
333-070-0105	1-1-2017	Repeal	1-1-2017
333-070-0110	1-1-2017	Repeal	1-1-2017
333-070-0115	1-1-2017	Am. & Ren.	1-1-2017
333-070-0120	1-1-2017	Am. & Ren.	1-1-2017
333-070-0125	1-1-2017	Repeal	1-1-2017

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333-070-0135	1-1-2017	Repeal	1-1-2017
333-070-0140	1-1-2017	Repeal	1-1-2017
333-070-0145	1-1-2017	Am. & Ren.	1-1-2017
333-070-0150	1-1-2017	Repeal	1-1-2017
333-070-0160	1-1-2017	Am. & Ren.	1-1-2017
333-070-0200	1-1-2017	Adopt	1-1-2017
407-007-0210	12-1-2016	Amend	1-1-2017
407-007-0210(T)	12-1-2016	Repeal	1-1-2017
407-007-0250	12-1-2016	Amend	1-1-2017
407-007-0250(T)	12-1-2016	Repeal	1-1-2017
407-007-0279	12-1-2016	Amend	1-1-2017
407-007-0279(T)	12-1-2016	Repeal	1-1-2017
407-007-0290	12-1-2016	Amend	1-1-2017
407-007-0290(T)	12-1-2016	Repeal	1-1-2017
407-007-0320	12-1-2016	Amend	1-1-2017
407-007-0320(T)	12-1-2016	Repeal	1-1-2017
407-007-0330	12-1-2016	Amend	1-1-2017
407-007-0330(T)	12-1-2016	Repeal	1-1-2017
407-045-0800	12-1-2016	Amend	1-1-2017
407-045-0810(T)	12-1-2016	Repeal	1-1-2017
407-045-0820	12-1-2016	Amend	1-1-2017
407-045-0825	12-1-2016	Adopt	1-1-2017
407-045-0830(T)	12-1-2016	Repeal	1-1-2017
407-045-0850(T)	12-1-2016	Repeal	1-1-2017
407-045-0860(T)	12-1-2016	Repeal	1-1-2017
407-045-0870(T)	12-1-2016	Repeal	1-1-2017
407-045-0880(T)	12-1-2016	Repeal	1-1-2017
407-045-0885	12-1-2016	Adopt	1-1-2017
407-045-0886	12-1-2016	Adopt	1-1-2017
407-045-0887	12-1-2016	Adopt	1-1-2017
407-045-0890	12-1-2016	Amend	1-1-2017
407-045-0895	12-1-2016	Adopt	1-1-2017
407-045-0900(T)	12-1-2016	Repeal	1-1-2017
407-045-0910	12-1-2016	Amend	1-1-2017
407-045-0920(T)	12-1-2016	Repeal	1-1-2017
407-045-0930(T)	12-1-2016	Repeal	1-1-2017
407-045-0940	12-1-2016	Amend	1-1-2017
407-045-0950	12-1-2016	Amend	1-1-2017
407-045-0955	12-1-2016	Adopt	1-1-2017
407-045-0960(T)	12-1-2016	Repeal	1-1-2017
407-045-0970(T)	12-1-2016	Repeal	1-1-2017
407-045-0980	12-1-2016	Repeal	1-1-2017
409-110-0025	11-29-2016	Renumber	1-1-2017
409-110-0030	11-29-2016	Renumber	1-1-2017
409-110-0035	11-29-2016	Renumber	1-1-2017
409-110-0040	11-29-2016	Renumber	1-1-2017
409-110-0045	11-29-2016	Renumber	1-1-2017
410-121-0030	12-1-2016	Amend	1-1-2017
410-121-0030(T)	12-1-2016	Repeal	1-1-2017
410-121-0040	12-1-2016	Amend	1-1-2017
410-121-0040(T)	12-1-2016	Repeal	1-1-2017
410-129-0020	1-1-2017	Amend(T)	1-1-2017
410-129-0040	1-1-2017	Amend(T)	1-1-2017
410-129-0070	1-1-2017	Amend(T)	1-1-2017
410-129-0190	1-1-2017	Suspend	1-1-2017
410-131-0040	1-1-2017	Amend(T)	1-1-2017
410-131-0080	1-1-2017	Amend(T)	1-1-2017
410-131-0100	1-1-2017	Amend(T)	1-1-2017
410-131-0120	1-1-2017	Amend(T)	1-1-2017
410-141-0520	12-1-2016	Amend	1-1-2017
410-141-0520(T)	12-1-2016	Repeal	1-1-2017
410-141-3435	12-1-2016	Amend	1-1-2017
410-170-0110	11-29-2016	Amend	1-1-2017
410-170-0110(T)	11-29-2016	Repeal	1-1-2017
411-027-0170	12-28-2016	Amend	1-1-2017
413-010-0000	12-1-2016	Amend	1-1-2017
413-010-0500	12-1-2016	Amend	1-1-2017
413-010-0501	12-1-2016	Repeal	1-1-2017
413-010-0502	12-1-2016	Amend	1-1-2017
413-010-0505	12-1-2016	Amend	1-1-2017
413-010-0510	12-1-2016	Amend	1-1-2017
413-010-0525	12-1-2016	Amend	1-1-2017
413-010-0535	12-1-2016	Amend	1-1-2017
413-015-0100	12-1-2016	Amend	1-1-2017
413-015-0100(T)	12-1-2016	Repeal	1-1-2017
413-015-0115	12-1-2016	Amend	1-1-2017
413-015-0125	12-1-2016	Amend	1-1-2017
413-015-0125(T)	12-1-2016	Repeal	1-1-2017
413-015-0205	12-1-2016	Amend	1-1-2017
413-015-0205(T)	12-1-2016	Repeal	1-1-2017
413-015-0212	12-1-2016	Amend	1-1-2017
413-015-0212(T)	12-1-2016	Repeal	1-1-2017
413-015-0300	12-1-2016	Amend	1-1-2017
413-015-0300(T)	12-1-2016	Repeal	1-1-2017
413-015-0409	12-1-2016	Amend	1-1-2017
413-015-0409(T)	12-1-2016	Repeal	1-1-2017
413-015-0420	12-1-2016	Amend	1-1-2017
413-015-0420(T)	12-1-2016	Repeal	1-1-2017
413-015-0440	12-1-2016	Amend	1-1-2017
413-015-0440(T)	12-1-2016	Repeal	1-1-2017
413-015-0445	12-1-2016	Amend	1-1-2017
413-015-0445(T)	12-1-2016	Repeal	1-1-2017
413-015-0450	12-1-2016	Amend	1-1-2017
413-015-0450(T)	12-1-2016	Repeal	1-1-2017
413-015-0620	12-1-2016	Adopt	1-1-2017
413-015-0620(T)	12-1-2016	Repeal	1-1-2017
413-015-0625	12-1-2016	Adopt	1-1-2017
413-015-0625(T)	12-1-2016	Repeal	1-1-2017
413-015-0630	12-1-2016	Adopt	1-1-2017
413-015-0630(T)	12-1-2016	Repeal	1-1-2017
413-015-0640	12-1-2016	Adopt	1-1-2017
413-015-0640(T)	12-1-2016	Repeal	1-1-2017
413-015-1000	12-1-2016	Amend	1-1-2017
413-015-1000(T)	12-1-2016	Repeal	1-1-2017
413-015-9030	12-1-2016	Amend	1-1-2017
413-015-9030(T)	12-1-2016	Repeal	1-1-2017
413-015-9040	12-1-2016	Amend	1-1-2017
413-015-9040(T)	12-1-2016	Repeal	1-1-2017
413-080-0050	12-1-2016	Amend	1-1-2017
413-080-0050(T)	12-1-2016	Repeal	1-1-2017
413-080-0051	12-1-2016	Adopt	1-1-2017

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413-080-0052(T)	12-1-2016	Repeal	1-1-2017
413-080-0054	12-1-2016	Amend	1-1-2017
413-080-0054(T)	12-1-2016	Repeal	1-1-2017
413-080-0059	12-1-2016	Amend	1-1-2017
413-080-0059(T)	12-1-2016	Repeal	1-1-2017
413-080-0070	12-1-2016	Adopt	1-1-2017
413-080-0070(T)	12-1-2016	Repeal	1-1-2017
413-090-0000	12-1-2016	Amend	1-1-2017
413-090-0000(T)	12-1-2016	Repeal	1-1-2017
413-090-0055	12-1-2016	Amend	1-1-2017
413-090-0055(T)	12-1-2016	Repeal	1-1-2017
413-090-0065	12-1-2016	Amend	1-1-2017
413-090-0065(T)	12-1-2016	Repeal	1-1-2017
413-090-0070	12-1-2016	Amend	1-1-2017
413-090-0070(T)	12-1-2016	Repeal	1-1-2017
413-090-0075	12-1-2016	Amend	1-1-2017
413-090-0075(T)	12-1-2016	Repeal	1-1-2017
413-090-0080	12-1-2016	Amend	1-1-2017
413-090-0080(T)	12-1-2016	Repeal	1-1-2017
413-090-0090	12-1-2016	Amend	1-1-2017
413-090-0090(T)	12-1-2016	Repeal	1-1-2017
413-215-0000	12-1-2016	Adopt	1-1-2017
413-215-0000(T)	12-1-2016	Repeal	1-1-2017
413-215-0001	12-1-2016	Amend	1-1-2017
413-215-0001(T)	12-1-2016	Repeal	1-1-2017
413-215-0006	12-1-2016	Repeal	1-1-2017
413-215-0011	12-1-2016	Amend	1-1-2017
413-215-0011(T)	12-1-2016	Repeal	1-1-2017
413-215-0016	12-1-2016	Amend	1-1-2017
413-215-0016(T)	12-1-2016	Repeal	1-1-2017
413-215-0021	12-1-2016	Amend	1-1-2017
413-215-0021(T)	12-1-2016	Repeal	1-1-2017
413-215-0026	12-1-2016	Amend	1-1-2017
413-215-0026(T)	12-1-2016	Repeal	1-1-2017
413-215-0031	12-1-2016	Amend	1-1-2017
413-215-0031(T)	12-1-2016	Repeal	1-1-2017
413-215-0036	12-1-2016	Amend	1-1-2017
413-215-0036(T)	12-1-2016	Repeal	1-1-2017
413-215-0041	12-1-2016	Amend	1-1-2017
413-215-0041(T)	12-1-2016	Repeal	1-1-2017
413-215-0046	12-1-2016	Amend	1-1-2017
413-215-0046(T)	12-1-2016	Repeal	1-1-2017
413-215-0051	12-1-2016	Amend	1-1-2017
413-215-0051(T)	12-1-2016	Repeal	1-1-2017
413-215-0056	12-1-2016	Amend	1-1-2017
413-215-0056(T)	12-1-2016	Repeal	1-1-2017
413-215-0061	12-1-2016	Amend	1-1-2017
413-215-0061(T)	12-1-2016	Repeal	1-1-2017
413-215-0066	12-1-2016	Amend	1-1-2017
413-215-0066(T)	12-1-2016	Repeal	1-1-2017
413-215-0071	12-1-2016	Amend	1-1-2017
413-215-0071(T)	12-1-2016	Repeal	1-1-2017
413-215-0076	12-1-2016	Amend	1-1-2017
413-215-0076(T)	12-1-2016	Repeal	1-1-2017
413-215-0081	12-1-2016	Amend	1-1-2017
413-215-0081(T)	12-1-2016	Repeal	1-1-2017
413-215-0086	12-1-2016	Amend	1-1-2017
413-215-0086(T)	12-1-2016	Repeal	1-1-2017
413-215-0091	12-1-2016	Amend	1-1-2017
413-215-0091(T)	12-1-2016	Repeal	1-1-2017
413-215-0096	12-1-2016	Repeal	1-1-2017
413-215-0101	12-1-2016	Amend	1-1-2017
413-215-0101(T)	12-1-2016	Repeal	1-1-2017
413-215-0106	12-1-2016	Amend	1-1-2017
413-215-0106(T)	12-1-2016	Repeal	1-1-2017
413-215-0111	12-1-2016	Amend	1-1-2017
413-215-0111(T)	12-1-2016	Repeal	1-1-2017
413-215-0116	12-1-2016	Amend	1-1-2017
413-215-0116(T)	12-1-2016	Repeal	1-1-2017
413-215-0121	12-1-2016	Amend	1-1-2017
413-215-0121(T)	12-1-2016	Repeal	1-1-2017
413-215-0126	12-1-2016	Amend	1-1-2017
413-215-0126(T)	12-1-2016	Repeal	1-1-2017
413-215-0131	12-1-2016	Amend	1-1-2017
413-215-0131(T)	12-1-2016	Repeal	1-1-2017
413-215-0201	12-1-2016	Amend	1-1-2017
413-215-0201(T)	12-1-2016	Repeal	1-1-2017
413-215-0206	12-1-2016	Repeal	1-1-2017
413-215-0211	12-1-2016	Amend	1-1-2017
413-215-0211(T)	12-1-2016	Repeal	1-1-2017
413-215-0216	12-1-2016	Amend	1-1-2017
413-215-0216(T)	12-1-2016	Repeal	1-1-2017
413-215-0218	12-1-2016	Adopt	1-1-2017
413-215-0221	12-1-2016	Amend	1-1-2017
413-215-0221(T)	12-1-2016	Repeal	1-1-2017
413-215-0226	12-1-2016	Amend	1-1-2017
413-215-0226(T)	12-1-2016	Repeal	1-1-2017
413-215-0231	12-1-2016	Amend	1-1-2017
413-215-0231(T)	12-1-2016	Repeal	1-1-2017
413-215-0236	12-1-2016	Amend	1-1-2017
413-215-0236(T)	12-1-2016	Repeal	1-1-2017
413-215-0241	12-1-2016	Amend	1-1-2017
413-215-0241(T)	12-1-2016	Repeal	1-1-2017
413-215-0246	12-1-2016	Amend	1-1-2017
413-215-0246(T)	12-1-2016	Repeal	1-1-2017
413-215-0251	12-1-2016	Amend	1-1-2017
413-215-0251(T)	12-1-2016	Repeal	1-1-2017
413-215-0256	12-1-2016	Repeal	1-1-2017
413-215-0261	12-1-2016	Amend	1-1-2017
413-215-0261(T)	12-1-2016	Repeal	1-1-2017
413-215-0266	12-1-2016	Amend	1-1-2017
413-215-0266(T)	12-1-2016	Repeal	1-1-2017
413-215-0271	12-1-2016	Amend	1-1-2017
413-215-0271(T)	12-1-2016	Repeal	1-1-2017
413-215-0276	12-1-2016	Amend	1-1-2017
413-215-0276(T)	12-1-2016	Repeal	1-1-2017
413-215-0301	12-1-2016	Amend	1-1-2017
413-215-0301(T)	12-1-2016	Repeal	1-1-2017
413-215-0306	12-1-2016	Repeal	1-1-2017
413-215-0311	12-1-2016	Amend	1-1-2017

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413-215-0313	12-1-2016	Amend	1-1-2017
413-215-0313(T)	12-1-2016	Repeal	1-1-2017
413-215-0316	12-1-2016	Amend	1-1-2017
413-215-0316(T)	12-1-2016	Repeal	1-1-2017
413-215-0318	12-1-2016	Adopt	1-1-2017
413-215-0321	12-1-2016	Amend	1-1-2017
413-215-0321(T)	12-1-2016	Repeal	1-1-2017
413-215-0326	12-1-2016	Amend	1-1-2017
413-215-0326(T)	12-1-2016	Repeal	1-1-2017
413-215-0331	12-1-2016	Amend	1-1-2017
413-215-0331(T)	12-1-2016	Repeal	1-1-2017
413-215-0336	12-1-2016	Amend	1-1-2017
413-215-0336(T)	12-1-2016	Repeal	1-1-2017
413-215-0341	12-1-2016	Amend	1-1-2017
413-215-0341(T)	12-1-2016	Repeal	1-1-2017
413-215-0346	12-1-2016	Repeal	1-1-2017
413-215-0349	12-1-2016	Amend	1-1-2017
413-215-0349(T)	12-1-2016	Repeal	1-1-2017
413-215-0351	12-1-2016	Amend	1-1-2017
413-215-0351(T)	12-1-2016	Repeal	1-1-2017
413-215-0356	12-1-2016	Amend	1-1-2017
413-215-0356(T)	12-1-2016	Repeal	1-1-2017
413-215-0361	12-1-2016	Amend	1-1-2017
413-215-0361(T)	12-1-2016	Repeal	1-1-2017
413-215-0366	12-1-2016	Amend	1-1-2017
413-215-0366(T)	12-1-2016	Repeal	1-1-2017
413-215-0371	12-1-2016	Amend	1-1-2017
413-215-0371(T)	12-1-2016	Repeal	1-1-2017
413-215-0376	12-1-2016	Amend	1-1-2017
413-215-0376(T)	12-1-2016	Repeal	1-1-2017
413-215-0381	12-1-2016	Amend	1-1-2017
413-215-0381(T)	12-1-2016	Repeal	1-1-2017
413-215-0386	12-1-2016	Amend	1-1-2017
413-215-0386(T)	12-1-2016	Repeal	1-1-2017
413-215-0391	12-1-2016	Amend	1-1-2017
413-215-0391(T)	12-1-2016	Repeal	1-1-2017
413-215-0396	12-1-2016	Amend	1-1-2017
413-215-0396(T)	12-1-2016	Repeal	1-1-2017
413-215-0401	12-1-2016	Amend	1-1-2017
413-215-0401(T)	12-1-2016	Repeal	1-1-2017
413-215-0406	12-1-2016	Repeal	1-1-2017
413-215-0411	12-1-2016	Amend	1-1-2017
413-215-0411(T)	12-1-2016	Repeal	1-1-2017
413-215-0416	12-1-2016	Amend	1-1-2017
413-215-0416(T)	12-1-2016	Repeal	1-1-2017
413-215-0421	12-1-2016	Amend	1-1-2017
413-215-0421(T)	12-1-2016	Repeal	1-1-2017
413-215-0426	12-1-2016	Amend	1-1-2017
413-215-0426(T)	12-1-2016	Repeal	1-1-2017
413-215-0431	12-1-2016	Amend	1-1-2017
413-215-0431(T)	12-1-2016	Repeal	1-1-2017
413-215-0436	12-1-2016	Amend	1-1-2017
413-215-0436(T)	12-1-2016	Repeal	1-1-2017
413-215-0441	12-1-2016	Amend	1-1-2017
413-215-0441(T)	12-1-2016	Repeal	1-1-2017
413-215-0446	12-1-2016	Amend	1-1-2017
413-215-0446(T)	12-1-2016	Repeal	1-1-2017
413-215-0451	12-1-2016	Amend	1-1-2017
413-215-0451(T)	12-1-2016	Repeal	1-1-2017
413-215-0456	12-1-2016	Amend	1-1-2017
413-215-0456(T)	12-1-2016	Repeal	1-1-2017
413-215-0461	12-1-2016	Amend	1-1-2017
413-215-0461(T)	12-1-2016	Repeal	1-1-2017
413-215-0466	12-1-2016	Amend	1-1-2017
413-215-0466(T)	12-1-2016	Repeal	1-1-2017
413-215-0471	12-1-2016	Amend	1-1-2017
413-215-0471(T)	12-1-2016	Repeal	1-1-2017
413-215-0476	12-1-2016	Amend	1-1-2017
413-215-0476(T)	12-1-2016	Repeal	1-1-2017
413-215-0481	12-1-2016	Amend	1-1-2017
413-215-0481(T)	12-1-2016	Repeal	1-1-2017
413-215-0501	12-1-2016	Amend	1-1-2017
413-215-0501(T)	12-1-2016	Repeal	1-1-2017
413-215-0506	12-1-2016	Repeal	1-1-2017
413-215-0511	12-1-2016	Amend	1-1-2017
413-215-0511(T)	12-1-2016	Repeal	1-1-2017
413-215-0516	12-1-2016	Amend	1-1-2017
413-215-0516(T)	12-1-2016	Repeal	1-1-2017
413-215-0521	12-1-2016	Amend	1-1-2017
413-215-0521(T)	12-1-2016	Repeal	1-1-2017
413-215-0526	12-1-2016	Amend	1-1-2017
413-215-0526(T)	12-1-2016	Repeal	1-1-2017
413-215-0531	12-1-2016	Amend	1-1-2017
413-215-0531(T)	12-1-2016	Repeal	1-1-2017
413-215-0536	12-1-2016	Amend	1-1-2017
413-215-0536(T)	12-1-2016	Repeal	1-1-2017
413-215-0541	12-1-2016	Amend	1-1-2017
413-215-0541(T)	12-1-2016	Repeal	1-1-2017
413-215-0546	12-1-2016	Amend	1-1-2017
413-215-0546(T)	12-1-2016	Repeal	1-1-2017
413-215-0551	12-1-2016	Amend	1-1-2017
413-215-0551(T)	12-1-2016	Repeal	1-1-2017
413-215-0554	12-1-2016	Amend	1-1-2017
413-215-0554(T)	12-1-2016	Repeal	1-1-2017
413-215-0556	12-1-2016	Amend	1-1-2017
413-215-0556(T)	12-1-2016	Repeal	1-1-2017
413-215-0561	12-1-2016	Amend	1-1-2017
413-215-0561(T)	12-1-2016	Repeal	1-1-2017
413-215-0566	12-1-2016	Amend	1-1-2017
413-215-0566(T)	12-1-2016	Repeal	1-1-2017
413-215-0571	12-1-2016	Amend	1-1-2017
413-215-0571(T)	12-1-2016	Repeal	1-1-2017
413-215-0576	12-1-2016	Amend	1-1-2017
413-215-0576(T)	12-1-2016	Repeal	1-1-2017
413-215-0581	12-1-2016	Amend	1-1-2017
413-215-0581(T)	12-1-2016	Repeal	1-1-2017
413-215-0586	12-1-2016	Amend	1-1-2017
413-215-0586(T)	12-1-2016	Repeal	1-1-2017
413-215-0601	12-1-2016	Amend	1-1-2017
413-215-0601(T)	12-1-2016	Repeal	1-1-2017
413-215-0606	12-1-2016	Repeal	1-1-2017

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413-215-0616	12-1-2016	Amend	1-1-2017
413-215-0616(T)	12-1-2016	Repeal	1-1-2017
413-215-0618	12-1-2016	Adopt	1-1-2017
413-215-0621	12-1-2016	Amend	1-1-2017
413-215-0621(T)	12-1-2016	Repeal	1-1-2017
413-215-0626	12-1-2016	Amend	1-1-2017
413-215-0626(T)	12-1-2016	Repeal	1-1-2017
413-215-0631	12-1-2016	Amend	1-1-2017
413-215-0631(T)	12-1-2016	Repeal	1-1-2017
413-215-0636	12-1-2016	Amend	1-1-2017
413-215-0636(T)	12-1-2016	Repeal	1-1-2017
413-215-0641	12-1-2016	Amend	1-1-2017
413-215-0641(T)	12-1-2016	Repeal	1-1-2017
413-215-0646	12-1-2016	Amend	1-1-2017
413-215-0646(T)	12-1-2016	Repeal	1-1-2017
413-215-0651	12-1-2016	Amend	1-1-2017
413-215-0651(T)	12-1-2016	Repeal	1-1-2017
413-215-0656	12-1-2016	Amend	1-1-2017
413-215-0656(T)	12-1-2016	Repeal	1-1-2017
413-215-0661	12-1-2016	Amend	1-1-2017
413-215-0661(T)	12-1-2016	Repeal	1-1-2017
413-215-0666	12-1-2016	Amend	1-1-2017
413-215-0666(T)	12-1-2016	Repeal	1-1-2017
413-215-0671	12-1-2016	Amend	1-1-2017
413-215-0671(T)	12-1-2016	Repeal	1-1-2017
413-215-0676	12-1-2016	Amend	1-1-2017
413-215-0676(T)	12-1-2016	Repeal	1-1-2017
413-215-0681	12-1-2016	Amend	1-1-2017
413-215-0681(T)	12-1-2016	Repeal	1-1-2017
413-215-0701	12-1-2016	Amend	1-1-2017
413-215-0701(T)	12-1-2016	Repeal	1-1-2017
413-215-0706	12-1-2016	Repeal	1-1-2017
413-215-0711	12-1-2016	Amend	1-1-2017
413-215-0711(T)	12-1-2016	Repeal	1-1-2017
413-215-0716	12-1-2016	Amend	1-1-2017
413-215-0716(T)	12-1-2016	Repeal	1-1-2017
413-215-0721	12-1-2016	Amend	1-1-2017
413-215-0721(T)	12-1-2016	Repeal	1-1-2017
413-215-0726	12-1-2016	Amend	1-1-2017
413-215-0726(T)	12-1-2016	Repeal	1-1-2017
413-215-0731	12-1-2016	Amend	1-1-2017
413-215-0731(T)	12-1-2016	Repeal	1-1-2017
413-215-0736	12-1-2016	Amend	1-1-2017
413-215-0736(T)	12-1-2016	Repeal	1-1-2017
413-215-0741	12-1-2016	Amend	1-1-2017
413-215-0741(T)	12-1-2016	Repeal	1-1-2017
413-215-0746	12-1-2016	Amend	1-1-2017
413-215-0746(T)	12-1-2016	Repeal	1-1-2017
413-215-0751	12-1-2016	Amend	1-1-2017
413-215-0751(T)	12-1-2016	Repeal	1-1-2017
413-215-0756	12-1-2016	Amend	1-1-2017
413-215-0756(T)	12-1-2016	Repeal	1-1-2017
413-215-0761	12-1-2016	Amend	1-1-2017
413-215-0761(T)	12-1-2016	Repeal	1-1-2017
413-215-0766	12-1-2016	Amend	1-1-2017
413-215-0766(T)	12-1-2016	Repeal	1-1-2017
413-215-0801	12-1-2016	Amend	1-1-2017
413-215-0801(T)	12-1-2016	Repeal	1-1-2017
413-215-0806	12-1-2016	Repeal	1-1-2017
413-215-0811	12-1-2016	Amend	1-1-2017
413-215-0811(T)	12-1-2016	Repeal	1-1-2017
413-215-0816	12-1-2016	Amend	1-1-2017
413-215-0816(T)	12-1-2016	Repeal	1-1-2017
413-215-0821	12-1-2016	Amend	1-1-2017
413-215-0821(T)	12-1-2016	Repeal	1-1-2017
413-215-0826	12-1-2016	Amend	1-1-2017
413-215-0826(T)	12-1-2016	Repeal	1-1-2017
413-215-0831	12-1-2016	Amend	1-1-2017
413-215-0831(T)	12-1-2016	Repeal	1-1-2017
413-215-0836	12-1-2016	Amend	1-1-2017
413-215-0836(T)	12-1-2016	Repeal	1-1-2017
413-215-0841	12-1-2016	Amend	1-1-2017
413-215-0841(T)	12-1-2016	Repeal	1-1-2017
413-215-0846	12-1-2016	Amend	1-1-2017
413-215-0846(T)	12-1-2016	Repeal	1-1-2017
413-215-0851	12-1-2016	Amend	1-1-2017
413-215-0851(T)	12-1-2016	Repeal	1-1-2017
413-215-0856	12-1-2016	Amend	1-1-2017
413-215-0856(T)	12-1-2016	Repeal	1-1-2017
413-215-0901	12-1-2016	Amend	1-1-2017
413-215-0901(T)	12-1-2016	Repeal	1-1-2017
413-215-0906	12-1-2016	Repeal	1-1-2017
413-215-0911	12-1-2016	Repeal	1-1-2017
413-215-0916	12-1-2016	Amend	1-1-2017
413-215-0916(T)	12-1-2016	Repeal	1-1-2017
413-215-0918	12-1-2016	Amend	1-1-2017
413-215-0921	12-1-2016	Amend	1-1-2017
413-215-0921(T)	12-1-2016	Repeal	1-1-2017
413-215-0926	12-1-2016	Amend	1-1-2017
413-215-0926(T)	12-1-2016	Repeal	1-1-2017
413-215-0931	12-1-2016	Amend	1-1-2017
413-215-0931(T)	12-1-2016	Repeal	1-1-2017
413-215-0936	12-1-2016	Amend	1-1-2017
413-215-0936(T)	12-1-2016	Repeal	1-1-2017
413-215-0941	12-1-2016	Amend	1-1-2017
413-215-0941(T)	12-1-2016	Repeal	1-1-2017
413-215-0946	12-1-2016	Amend	1-1-2017
413-215-0946(T)	12-1-2016	Repeal	1-1-2017
413-215-0951	12-1-2016	Amend	1-1-2017
413-215-0951(T)	12-1-2016	Repeal	1-1-2017
413-215-0956	12-1-2016	Amend	1-1-2017
413-215-0956(T)	12-1-2016	Repeal	1-1-2017
413-215-0961	12-1-2016	Amend	1-1-2017
413-215-0961(T)	12-1-2016	Repeal	1-1-2017
413-215-0966	12-1-2016	Amend	1-1-2017
413-215-0966(T)	12-1-2016	Repeal	1-1-2017
413-215-0971	12-1-2016	Amend	1-1-2017
413-215-0971(T)	12-1-2016	Repeal	1-1-2017
413-215-0976	12-1-2016	Amend	1-1-2017
413-215-0976(T)	12-1-2016	Repeal	1-1-2017

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413-215-0986	12-1-2016	Amend	1-1-2017
413-215-0986(T)	12-1-2016	Repeal	1-1-2017
413-215-0991	12-1-2016	Amend	1-1-2017
413-215-0991(T)	12-1-2016	Repeal	1-1-2017
413-215-0992	12-1-2016	Amend	1-1-2017
413-215-0992(T)	12-1-2016	Repeal	1-1-2017
413-215-0996	12-1-2016	Amend	1-1-2017
413-215-0996(T)	12-1-2016	Repeal	1-1-2017
413-215-1001	12-1-2016	Amend	1-1-2017
413-215-1001(T)	12-1-2016	Repeal	1-1-2017
413-215-1006	12-1-2016	Amend	1-1-2017
413-215-1006(T)	12-1-2016	Repeal	1-1-2017
413-215-1011	12-1-2016	Amend	1-1-2017
413-215-1011(T)	12-1-2016	Repeal	1-1-2017
413-215-1016	12-1-2016	Amend	1-1-2017
413-215-1016(T)	12-1-2016	Repeal	1-1-2017
413-215-1021	12-1-2016	Amend	1-1-2017
413-215-1021(T)	12-1-2016	Repeal	1-1-2017
413-215-1026	12-1-2016	Amend	1-1-2017
413-215-1026(T)	12-1-2016	Repeal	1-1-2017
413-215-1031	12-1-2016	Amend	1-1-2017
413-215-1031(T)	12-1-2016	Repeal	1-1-2017
415-012-0000	12-14-2016	Amend	1-1-2017
415-012-0010	12-14-2016	Amend	1-1-2017
415-012-0020	12-14-2016	Amend	1-1-2017
415-012-0030	12-14-2016	Amend	1-1-2017
415-012-0035	12-14-2016	Amend	1-1-2017
415-012-0040	12-14-2016	Amend	1-1-2017
415-012-0050	12-14-2016	Amend	1-1-2017
415-012-0055	12-14-2016	Amend	1-1-2017
415-012-0060	12-14-2016	Amend	1-1-2017
415-012-0065	12-14-2016	Amend	1-1-2017
415-012-0067	12-14-2016	Amend	1-1-2017
415-012-0090	12-14-2016	Amend	1-1-2017
415-020-0000	12-14-2016	Amend	1-1-2017
415-020-0005	12-14-2016	Amend	1-1-2017
415-020-0010	12-14-2016	Amend	1-1-2017
415-020-0090	12-14-2016	Amend	1-1-2017
415-055-0000	12-5-2016	Amend	1-1-2017
415-055-0010	12-5-2016	Amend	1-1-2017
415-055-0035	12-5-2016	Amend	1-1-2017
415-060-0010	12-14-2016	Repeal	1-1-2017
415-060-0020	12-14-2016	Repeal	1-1-2017
415-060-0030	12-14-2016	Repeal	1-1-2017
415-060-0040	12-14-2016	Repeal	1-1-2017
415-060-0050	12-14-2016	Repeal	1-1-2017
416-335-0090	12-8-2016	Amend	1-1-2017
436-050-0001	1-1-2017	Repeal	1-1-2017
436-050-0002	1-1-2017	Repeal	1-1-2017
436-050-0003	1-1-2017	Amend	1-1-2017
436-050-0005	1-1-2017	Amend	1-1-2017
436-050-0006	1-1-2017	Repeal	1-1-2017
436-050-0008	1-1-2017	Amend	1-1-2017
436-050-0015	1-1-2017	Amend	1-1-2017
436-050-0025	1-1-2017	Amend	1-1-2017
436-050-0040	1-1-2017	Amend	1-1-2017
436-050-0045	1-1-2017	Amend	1-1-2017
436-050-0050	1-1-2017	Amend	1-1-2017
436-050-0055	1-1-2017	Amend	1-1-2017
436-050-0060	1-1-2017	Repeal	1-1-2017
436-050-0110	1-1-2017	Amend	1-1-2017
436-050-0120	1-1-2017	Amend	1-1-2017
436-050-0150	1-1-2017	Amend	1-1-2017
436-050-0160	1-1-2017	Amend	1-1-2017
436-050-0165	1-1-2017	Amend	1-1-2017
436-050-0170	1-1-2017	Amend	1-1-2017
436-050-0175	1-1-2017	Amend	1-1-2017
436-050-0180	1-1-2017	Amend	1-1-2017
436-050-0185	1-1-2017	Amend	1-1-2017
436-050-0190	1-1-2017	Amend	1-1-2017
436-050-0195	1-1-2017	Amend	1-1-2017
436-050-0200	1-1-2017	Amend	1-1-2017
436-050-0205	1-1-2017	Amend	1-1-2017
436-050-0210	1-1-2017	Amend	1-1-2017
436-050-0220	1-1-2017	Amend	1-1-2017
436-050-0230	1-1-2017	Amend	1-1-2017
436-050-0260	1-1-2017	Amend	1-1-2017
436-050-0270	1-1-2017	Amend	1-1-2017
436-050-0280	1-1-2017	Amend	1-1-2017
436-050-0290	1-1-2017	Amend	1-1-2017
436-050-0300	1-1-2017	Amend	1-1-2017
436-050-0340	1-1-2017	Amend	1-1-2017
436-050-0400	1-1-2017	Amend	1-1-2017
436-050-0410	1-1-2017	Amend	1-1-2017
436-050-0420	1-1-2017	Amend	1-1-2017
436-050-0440	1-1-2017	Amend	1-1-2017
436-050-0450	1-1-2017	Amend	1-1-2017
436-050-0455	1-1-2017	Amend	1-1-2017
436-050-0460	1-1-2017	Amend	1-1-2017
436-050-0470	1-1-2017	Amend	1-1-2017
436-050-0480	1-1-2017	Amend	1-1-2017
436-060-0001	1-1-2017	Repeal	1-1-2017
436-060-0002	1-1-2017	Repeal	1-1-2017
436-060-0003	1-1-2017	Amend	1-1-2017
436-060-0005	1-1-2017	Amend	1-1-2017
436-060-0006	1-1-2017	Repeal	1-1-2017
436-060-0008	1-1-2017	Amend	1-1-2017
436-060-0009	1-1-2017	Amend	1-1-2017
436-060-0010	1-1-2017	Amend	1-1-2017
436-060-0011	1-1-2017	Adopt	1-1-2017
436-060-0015	1-1-2017	Amend	1-1-2017
436-060-0017	1-1-2017	Amend	1-1-2017
436-060-0018	1-1-2017	Amend	1-1-2017
436-060-0019	1-1-2017	Amend	1-1-2017
436-060-0020	1-1-2017	Amend	1-1-2017
436-060-0025	1-1-2017	Amend	1-1-2017
436-060-0030	1-1-2017	Amend	1-1-2017
436-060-0035	1-1-2017	Amend	1-1-2017
436-060-0040	1-1-2017	Amend	1-1-2017
436-060-0045	1-1-2017	Amend	1-1-2017

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436-060-0105	1-1-2017	Amend	1-1-2017
436-060-0135	1-1-2017	Amend	1-1-2017
436-060-0137	1-1-2017	Amend	1-1-2017
436-060-0140	1-1-2017	Amend	1-1-2017
436-060-0147	1-1-2017	Amend	1-1-2017
436-060-0150	1-1-2017	Amend	1-1-2017
436-060-0153	1-1-2017	Amend	1-1-2017
436-060-0155	1-1-2017	Amend	1-1-2017
436-060-0160	1-1-2017	Amend	1-1-2017
436-060-0170	1-1-2017	Amend	1-1-2017
436-060-0180	1-1-2017	Amend	1-1-2017
436-060-0190	1-1-2017	Amend	1-1-2017
436-060-0195	1-1-2017	Amend	1-1-2017
436-060-0200	1-1-2017	Amend	1-1-2017
436-060-0400	1-1-2017	Amend	1-1-2017
436-060-0500	1-1-2017	Amend	1-1-2017
436-060-0510	1-1-2017	Amend	1-1-2017
436-105-0001	1-1-2017	Repeal	1-1-2017
436-105-0002	1-1-2017	Repeal	1-1-2017
436-105-0003	1-1-2017	Amend	1-1-2017
436-105-0005	1-1-2017	Amend	1-1-2017
436-105-0006	1-1-2017	Amend	1-1-2017
436-105-0008	1-1-2017	Amend	1-1-2017
436-105-0500	1-1-2017	Amend	1-1-2017
436-105-0510	1-1-2017	Amend	1-1-2017
436-105-0511	1-1-2017	Amend	1-1-2017
436-105-0512	1-1-2017	Amend	1-1-2017
436-105-0520	1-1-2017	Amend	1-1-2017
436-105-0530	1-1-2017	Amend	1-1-2017
436-105-0540	1-1-2017	Amend	1-1-2017
436-105-0550	1-1-2017	Amend	1-1-2017
436-105-0560	1-1-2017	Amend	1-1-2017
436-110-0001	1-1-2017	Repeal	1-1-2017
436-110-0002	1-1-2017	Repeal	1-1-2017
436-110-0003	1-1-2017	Amend	1-1-2017
436-110-0005	1-1-2017	Amend	1-1-2017
436-110-0006	1-1-2017	Amend	1-1-2017
436-110-0007	1-1-2017	Amend	1-1-2017
436-110-0150	1-1-2017	Amend	1-1-2017
436-110-0240	1-1-2017	Amend	1-1-2017
436-110-0290	1-1-2017	Amend	1-1-2017
436-110-0310	1-1-2017	Amend	1-1-2017
436-110-0320	1-1-2017	Amend	1-1-2017
436-110-0325	1-1-2017	Amend	1-1-2017
436-110-0330	1-1-2017	Amend	1-1-2017
436-110-0335	1-1-2017	Amend	1-1-2017
436-110-0336	1-1-2017	Amend	1-1-2017
436-110-0337	1-1-2017	Amend	1-1-2017
436-110-0345	1-1-2017	Amend	1-1-2017
436-110-0346	1-1-2017	Amend	1-1-2017
436-110-0347	1-1-2017	Amend	1-1-2017
436-110-0350	1-1-2017	Amend	1-1-2017
436-110-0351	1-1-2017	Amend	1-1-2017
436-110-0352	1-1-2017	Amend	1-1-2017
436-110-0850	1-1-2017	Amend	1-1-2017
436-110-0900	1-1-2017	Amend	1-1-2017
436-120-0001	1-1-2017	Repeal	1-1-2017
436-120-0002	1-1-2017	Repeal	1-1-2017
436-120-0003	1-1-2017	Amend	1-1-2017
436-120-0005	1-1-2017	Amend	1-1-2017
436-120-0006	1-1-2017	Repeal	1-1-2017
436-120-0007	1-1-2017	Am. & Ren.	1-1-2017
436-120-0008	1-1-2017	Amend	1-1-2017
436-120-0012	1-1-2017	Amend	1-1-2017
436-120-0014	1-1-2017	Repeal	1-1-2017
436-120-0016	1-1-2017	Repeal	1-1-2017
436-120-0017	1-1-2017	Repeal	1-1-2017
436-120-0018	1-1-2017	Repeal	1-1-2017
436-120-0115	1-1-2017	Amend	1-1-2017
436-120-0125	1-1-2017	Repeal	1-1-2017
436-120-0135	1-1-2017	Repeal	1-1-2017
436-120-0145	1-1-2017	Amend	1-1-2017
436-120-0155	1-1-2017	Am. & Ren.	1-1-2017
436-120-0165	1-1-2017	Amend	1-1-2017
436-120-0175	1-1-2017	Amend	1-1-2017
436-120-0185	1-1-2017	Amend	1-1-2017
436-120-0340	1-1-2017	Am. & Ren.	1-1-2017
436-120-0400	1-1-2017	Am. & Ren.	1-1-2017
436-120-0410	1-1-2017	Amend	1-1-2017
436-120-0430	1-1-2017	Am. & Ren.	1-1-2017
436-120-0443	1-1-2017	Amend	1-1-2017
436-120-0445	1-1-2017	Amend	1-1-2017
436-120-0448	1-1-2017	Am. & Ren.	1-1-2017
436-120-0449	1-1-2017	Repeal	1-1-2017
436-120-0451	1-1-2017	Am. & Ren.	1-1-2017
436-120-0455	1-1-2017	Am. & Ren.	1-1-2017
436-120-0500	1-1-2017	Amend	1-1-2017
436-120-0510	1-1-2017	Amend	1-1-2017
436-120-0520	1-1-2017	Amend	1-1-2017
436-120-0530	1-1-2017	Amend	1-1-2017
436-120-0700	1-1-2017	Amend	1-1-2017
436-120-0710	1-1-2017	Amend	1-1-2017
436-120-0720	1-1-2017	Amend	1-1-2017
436-120-0755	1-1-2017	Amend	1-1-2017
436-120-0800	1-1-2017	Amend	1-1-2017
436-120-0810	1-1-2017	Amend	1-1-2017
436-120-0820	1-1-2017	Amend	1-1-2017
436-120-0830	1-1-2017	Repeal	1-1-2017
436-120-0840	1-1-2017	Amend	1-1-2017
436-120-0900	1-1-2017	Amend	1-1-2017
436-120-0915	1-1-2017	Amend	1-1-2017
459-017-0060	1-1-2017	Amend	1-1-2017
461-120-0345	1-1-2017	Amend	1-1-2017
461-135-0730	1-1-2017	Amend	1-1-2017
461-135-0780	1-1-2017	Amend	1-1-2017
461-135-0820	1-1-2017	Amend	1-1-2017
461-140-0296	1-1-2017	Amend	1-1-2017
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461-145-0184	1-1-2017	Repeal	1-1-2017
461-145-0220	1-1-2017	Amend	1-1-2017
461-145-0417	1-1-2017	Adopt	1-1-2017
461-145-0550	1-1-2017	Amend	1-1-2017
461-145-0930	1-1-2017	Amend	1-1-2017
461-150-0050	1-1-2017	Amend	1-1-2017
461-155-0250	1-1-2017	Amend	1-1-2017
461-155-0270	1-1-2017	Amend	1-1-2017
461-155-0300	1-1-2017	Amend	1-1-2017
461-160-0580	1-1-2017	Amend	1-1-2017
461-160-0620	1-1-2017	Amend	1-1-2017
461-180-0050	1-1-2017	Amend	1-1-2017
573-050-0015	12-6-2016	Amend	1-1-2017
573-050-0016	12-6-2016	Amend	1-1-2017
573-050-0025	12-6-2016	Amend	1-1-2017
573-050-0040	12-6-2016	Amend	1-1-2017
573-050-0045	12-6-2016	Amend	1-1-2017
635-004-0215	1-1-2017	Amend	1-1-2017
635-004-0223	1-1-2017	Adopt	1-1-2017
635-004-0330	1-1-2017	Amend	1-1-2017
635-004-0350	1-1-2017	Amend	1-1-2017
635-004-0355	1-1-2017	Amend	1-1-2017
635-005-0240	1-1-2017	Amend	1-1-2017
635-005-0263	1-1-2017	Adopt	1-1-2017
635-005-0355	12-15-2016	Amend(T)	1-1-2017
635-005-0465	11-23-2016	Amend(T)	1-1-2017
635-005-0465	12-18-2016	Amend(T)	1-1-2017
635-005-0465(T)	12-18-2016	Suspend	1-1-2017
635-005-0505	11-21-2016	Amend(T)	1-1-2017
635-005-0915	1-1-2017	Amend	1-1-2017
635-006-0210	1-1-2017	Amend	1-1-2017
635-008-0170	11-17-2016	Amend	1-1-2017
635-008-0175	11-17-2016	Amend	1-1-2017
635-039-0090	1-1-2017	Amend	1-1-2017
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635-500-6720	12-15-2016	Amend	1-1-2017
635-500-6725	12-15-2016	Amend	1-1-2017
635-500-6730	12-15-2016	Amend	1-1-2017
635-500-6735	12-15-2016	Amend	1-1-2017
635-500-6740	12-15-2016	Amend	1-1-2017
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734-010-0290	11-28-2016	Amend	1-1-2017
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734-010-0320	11-28-2016	Amend	1-1-2017
734-010-0330	11-28-2016	Amend	1-1-2017
734-010-0340	11-28-2016	Amend	1-1-2017
734-010-0350	11-28-2016	Repeal	1-1-2017
734-010-0360	11-28-2016	Amend	1-1-2017
734-010-0380	11-28-2016	Amend	1-1-2017
734-059-0015	11-28-2016	Amend	1-1-2017
734-059-0200	11-28-2016	Amend	1-1-2017
734-060-0000	11-28-2016	Amend	1-1-2017
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735-024-0025	11-22-2016	Amend	1-1-2017
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824-030-0040	1-1-2017	Amend	1-1-2017
824-035-0005	1-1-2017	Repeal	1-1-2017
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824-050-0010	1-1-2017	Amend	1-1-2017
824-060-0010	1-1-2017	Amend	1-1-2017
824-070-0005	1-1-2017	Adopt	1-1-2017
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833-040-0041	12-12-2016	Amend(T)	1-1-2017
845-005-0412	1-1-2017	Adopt	1-1-2017
845-006-0500	12-1-2016	Amend	1-1-2017
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851-010-0010	1-1-2017	Amend	1-1-2017
851-010-0015	1-1-2017	Amend	1-1-2017
851-010-0020	1-1-2017	Repeal	1-1-2017
851-010-0024	1-1-2017	Amend	1-1-2017
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855-019-0460	12-14-2016	Adopt	1-1-2017
855-019-0460(T)	12-14-2016	Repeal	1-1-2017
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859-010-0005	11-18-2016	Amend	1-1-2017
859-510-0005	12-13-2016	Amend	1-1-2017
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860-032-0620	11-22-2016	Am. & Ren.	1-1-2017
860-032-0630	11-22-2016	Am. & Ren.	1-1-2017
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860-033-0046	12-2-2016	Amend(T)	1-1-2017
860-033-0050	12-2-2016	Amend(T)	1-1-2017
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860-087-0030	11-22-2016	Adopt	1-1-2017
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860-100-0005	11-22-2016	Adopt	1-1-2017
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875-010-0045	12-12-2016	Amend(T)	1-1-2017
875-010-0045	12-13-2016	Amend	1-1-2017
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875-015-0030	12-12-2016	Amend(T)	1-1-2017
875-030-0010	12-13-2016	Amend	1-1-2017
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