WSR 12-05-023
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed February 7, 2012, 12:32 p.m.]

Supplemental Notice to WSR 11-22-032.

Preproposal statement of inquiry was filed as WSR 11-15-104.

Title of Rule and Other Identifying Information: To implement ESHB 2082, Laws of 2011, the department is proposing to make the following changes: Amending WAC 388-273-0020, 388-406-0005, 388-406-0045, 388-406-0055, 388-408-0005, 388-416-0010, 388-424-0010, 388-424-0015, 388-436-0030, 388-442-0010, 388-450-0040, 388-450-0045, 388-450-0095, 388-450-0100, 388-450-0115, 388-450-0120, 388-450-0130, 388-450-0156, 388-450-0170, 388-460-0020, 388-460-0040, 388-468-0005, 388-473-0010, 388-474-0010, 388-474-0020, 388-476-0005, 388-478-0035 and 388-486-0005; repealing WAC 388-400-0025, 388-404-0010, 388-408-0010, 388-418-0025, 388-424-0016, 388-448-0001, 388-448-0010, 388-448-0020, 388-448-0030, 388-448-0035, 388-448-0040, 388-448-0050, 388-448-0060, 388-448-0070, 388-448-0080, 388-448-0090, 388-448-0100, 388-448-0110, 388-448-0120, 388-448-0130, 388-448-0140, 388-448-0150, 388-448-0160, 388-448-0180, 388-448-0200, 388-448-0210, 388-448-0220, 388-448-0250, 388-450-0110, 388-450-0135, 388-450-0175, 388-462-0011 and 388-478-0030; and creating WAC 388-400-0055, 388-400-0060, 388-408-0060, 388-449-0001, 388-449-0005, 388-449-0010, 388-449-0015, 388-449-0020, 388-449-0030, 388-449-0035, 388-449-0040, 388-449-0045, 388-449-0050, 388-449-0060, 388-449-0070, 388-449-0080, 388-449-0100, 388-449-0150, 388-449-0200, 388-449-0210, 388-449-0220, 388-449-0225, 388-450-0112, 388-450-0137, 388-450-0177, 388-478-0027, and 388-478-0033.

Hearing Location(s): Office Building 2, Lookout Room, DSHS Headquarters, 1115 Washington, Olympia, WA 98504 (public parking at 11th and Jefferson. A map is available at http://www1.dshs.wa.gov/msa/rpau/RPAU-OB-2directions.html or by calling (360) 664-6094), on April 10, 2012, at 10:00 a.m.

Date of Intended Adoption: Not earlier than April 11, 2012.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504-5850, delivery 1115 Washington Street S.E., Olympia, WA 98504, e-mail DSHSRPAURulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5 p.m. on April 10, 2012.

Assistance for Persons with Disabilities: Contact Jennisha Johnson, DSHS rules consultant, by March 27, 2012, TTY (360) 664-6178 or (360) 664-6094 or by e-mail at jennisha.johnson@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is amending, repealing and creating new rules to terminate all components of the disability lifeline program, and to establish the aged, blind, or disabled assistance and the pregnant women assistance programs to comply with ESHB 2082, Laws of 2011.

Reasons Supporting Proposal: These changes are necessary to conform to ESHB 2082, Laws of 2011. After the initial notice of proposed rule making was filed, the department made significant changes to the proposed language in chapter 388-449 WAC based on public comment and extensive feedback provided by legal advocates and interested stakeholders. This supplemental notice includes proposed rules substantially different from the proposed rules filed October 26, 2011, as WSR 11-22-032.

Statutory Authority for Adoption: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.100, 74.04.770, 74.04.0052, 74.04.655, 74.04.770, 74.08.043, 74.08.335.

Statute Being Implemented: ESHB 2082, Laws of 2011 1st sp. sess.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of social and health services, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Shane Riddle, 712 Pear Street S.E., Olympia, WA 98503, (360) 725-4352.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These proposed rules do not have an economic impact on small businesses. The proposed amendments only affect DSHS clients by defining eligibility for pregnant women assistance and aged, blind, or disabled cash assistance.

A cost-benefit analysis is not required under RCW 34.05.328. These amendments are exempt as allowed under RCW 34.05.328 (5)(b)(vii) which states in-part, "[t]his section does not apply to … rules of the department of social and health services relating only to client medical or financial eligibility and rules concerning liability for care of dependents."

February 6, 2012
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 02-18-106, filed 9/3/02, effective 10/4/02)

WAC 388-273-0020 Who may receive Washington telephone assistance program (WTAP)? (1) To receive WTAP benefits, you must:

(a) Be age eighteen or older or, if under eighteen, be the responsible head of household, and either;

(b) Be receiving one of the following programs from us:

(i) Temporary assistance for needy families (TANF);

(ii) State family assistance (SFA);

(iii) ((~~General assistance~~)) Pregnant women assistance (PWA);

(iv) Aged, blind, or disabled (ABD) cash assistance;

(v) Refugee assistance;

((~~(v)~~)) (vi) Food assistance;

((~~(vi)~~)) (vii) State Supplemental Security Income (SSI);

((~~(vii)~~)) (viii) Medical assistance, including medicare cost sharing programs;

((~~(viii)~~)) (ix) Community options program entry system (COPES);

((~~(ix)~~)) (x) Chore services; or

(c) Have completed using community service voice mail services, and been identified to the department as eligible for WTAP by the community agency that provided your community service voice mail program; and

(2) Apply to a local exchange company for WTAP and request the lowest available flat rate telephone service at the WTAP rate. In exchange areas where wireline service is not available without service extension, you may apply to a wireless carrier:

(a) **"Local exchange company"** means a telephone company that is required by the Washington utilities and transportation commission to offer WTAP benefits and offers local calling, i.e., calling without long distance charges.

(b) **"Flat rate service"** is telephone service with a single monthly payment that allows unlimited local calling for a specified length of time. The local exchange flat rate includes any federal end user access charges and other charges necessary to obtain the service; and

(3) You must have the local telephone service billed in your name.

NEW SECTION

WAC 388-400-0055 Who is eligible for the pregnant women assistance (PWA) program? Effective November 1, 2011:

(1) You can get pregnant women assistance (PWA), if you:

(a) Are pregnant as verified by a medical professional;

(b) Meet the citizenship/alien status requirements of WAC 388-424-0010;

(c) Live in the state of Washington per WAC 388-468-0005;

(d) Do not live in a public institution unless specifically allowed under RCW 74.08.025;

(e) Meet TANF/SFA:

(i) Income requirements under chapter 388-450 WAC;

(ii) Resource requirements under chapter 388-470 WAC; and

(iii) Transfer of property requirements under chapter 388-488 WAC.

(f) Tell us your social security number as required under WAC 388-476-0005;

(g) Report changes of circumstances as required under WAC 388-418-0005; and

(2) If you are an unmarried pregnant minor your living arrangements must meet the requirements of WAC 388-486-0005.

(3) You cannot get PWA if you:

(a) Are eligible for temporary assistance for needy families (TANF) benefits;

(b) Are eligible for state family assistance (SFA) benefits;

(c) Refuse or fail to meet a TANF or SFA eligibility rule;

(d) Refuse or fail to participate in drug or alcohol treatment as required in WAC 388-449-0220; or

(e) Are eligible for supplemental security income (SSI) benefits.

NEW SECTION

WAC 388-400-0060 Who is eligible for aged, blind or disabled (ABD) cash assistance? (1) Effective November 1, 2011, you are eligible for aged, blind, or disabled (ABD) cash benefits if you:

(a) Are:

(i) At least sixty-five years old;

(ii) Blind as defined by the Social Security Administration (SSA); or

(iii) Likely to be disabled as defined in WAC 388-449-0001 through 388-449-0100; and

(b) Are at least eighteen years old or, if under eighteen, a member of a married couple;

(c) Are in financial need according to ABD cash income and resource rules in chapters 388-450, 388-470 and 388-488 WAC. We determine who is in your assistance unit according to WAC 388-408-0060;

(d) Meet the citizenship/alien status requirements under WAC 388-424-0015;

(e) Provide a social security number as required under WAC 388-476-0005;

(f) Reside in the state of Washington as required under WAC 388-468-0005;

(g) Sign an interim assistance reimbursement authorization agreeing to repay the monetary value of general assistance, disability lifeline, or aged blind or disabled benefits subsequently duplicated by supplemental security income benefits as described under WAC 388-449-0200, 388-449-0210 and 388-474-0020;

(h) Report changes of circumstances as required under WAC 388-418-0005; and

(i) Complete a mid-certification review and provide proof of any changes as required under WAC 388-418-0011.

(2) You aren't eligible for aged, blind, or disabled cash benefits if you:

(a) Are eligible for temporary assistance for needy families (TANF) benefits;

(b) Are eligible for state family assistance (SFA) benefits;

(c) Refuse or fail to meet a TANF or SFA eligibility rule;

(d) Refuse or fail to participate in drug or alcohol treatment as required in WAC 388-449-0220;

(e) Refuse or fail to follow through with the SSI application as required in WAC 388-449-0200;

(f) Refuse or fail to participate in vocational rehabilitation services as required in WAC 388-449-0225;

(g) Are eligible for supplemental security income (SSI) benefits;

(h) Are an ineligible spouse of an SSI recipient; or

(i) Failed to follow a Social Security Administration (SSA) program rule or application requirement and SSA denied or terminated your benefits.

(3) If you reside in a public institution and meet all other requirements, your eligibility for ABD cash depends on the type of institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.

(a) You may be eligible for ABD cash if you are:

(i) A patient in a public medical institution; or

(ii) A patient in a public mental institution and:

(A) Sixty-five years of age or older; or

(B) Twenty years of age or younger.

(4) You aren't eligible for ABD cash when you are in the custody of or confined in a public institution such as a state penitentiary or county jail including placement:

(a) In a work release program; or

(b) Outside of the institution including home detention.

AMENDATORY SECTION (Amending WSR 09-19-129, filed 9/22/09, effective 11/1/09)

WAC 388-406-0005 Can I apply for cash, medical, or Basic Food? (1) You can apply for any benefit the department offers, including cash assistance, medical assistance, or Basic Food.

(2) You must meet certain eligibility requirements in order to receive a program benefit.

(3) You can apply for someone else if you are:

(a) A legal guardian, caretaker, or authorized representative applying for:

(i) A dependent child;

(ii) An incapacitated person; or

(iii) Someone who is deceased.

(b) Applying for someone who cannot apply for some other reason. We may ask why the applicant is unable to apply on their own behalf.

(4) If you get Supplemental Security Income (SSI), you do not need to apply for medical benefits. We automatically open medical benefits for you.

(5) A person or agency may apply for ((~~GAU~~)) ABD cash or medical assistance for you if:

(a) You temporarily live out-of-state; and

(b) You are a Washington state resident.

(6) When you are confined or incarcerated in a Washington state public institution, you may apply for cash or medical assistance if you meet the following criteria:

(a) You are confined by or in the following public institutions:

(i) Department of corrections;

(ii) City or county jail; or

(iii) Institution for mental diseases (IMD).

(b) Staff at the public institution provide medical records including diagnosis by a mental health professional that you have a mental disorder (as defined in the Diagnostic and Statistical Manual of Psychiatric Disorders, most recent edition) that affects your thoughts, mood or behavior so severely that it prevents you from performing any kind of work.

(7) We will make an eligibility determination for medical assistance prior to your release from confinement and will authorize medical benefits upon your release from confinement when you:

(a) Meet the criteria of subsection (6) in this section; and

(b) Were receiving medicaid ((~~or general assistance benefits~~)) immediately before confinement or within the five years prior to confinement.

(8) If you meet the criteria in subsection (6) but did not receive medicaid ((~~or general assistance benefits~~)) within the five years prior to confinement, the department will process your request for medical assistance within the time frames in WAC 388-406-0035.

(9) If you are applying for assistance for a youth leaving incarceration in a juvenile rehabilitation administration or county juvenile detention facility, you may apply for assistance within forty-five days prior to release. We will process your application for medical assistance when we receive it, and if eligible, we will authorize medical benefits upon the youth's release from confinement.

AMENDATORY SECTION (Amending WSR 09-19-129, filed 9/22/09, effective 11/1/09)

WAC 388-406-0045 Is there a good reason my application for cash or medical assistance has not been processed? If your application for cash or medical assistance is not processed within the time limits under WAC 388-406-0035, the department must decide if there is a good reason for the delay. This good reason is also called "good cause."

(1) We do not have a good reason for not processing your application for TANF or SFA within thirty days if:

(a) We did not give or send you a notice of what information we needed to determine your eligibility within twenty days from the date of your application;

(b) We did not give or send you a notice that we needed additional information or action within five calendar days of the date we learned that more information was needed to determine eligibility;

(c) We did not process your application within five calendar days from getting the information needed to decide eligibility; and

(d) We decide good cause exists but do not document our decision in the case record on or before the time limit for processing the application ends.

(2) We do have a good reason for not processing your application timely if:

(a) You do not give us the information or take an action needed for us to determine eligibility;

(b) We have an emergency beyond our control; or

(c) There is no other available verification for us to determine eligibility and the eligibility decision depends on information that has been delayed such as:

(i) Medical documentation;

(ii) For cash assistance, extensive property appraisals; or

(iii) Out-of-state documents or correspondence.

(3) For medical assistance, good cause exists only when the department otherwise acted promptly at all stages of the application process.

(4) For ((~~general assistance (GA)~~)) ABD cash assistance, good cause exists if you apply when you are confined in a Washington State public institution as defined in WAC 388-406-0005 (6)(a).

AMENDATORY SECTION (Amending WSR 10-11-033, filed 5/11/10, effective 7/1/10)

WAC 388-406-0055 When do my benefits start? The date we approve your application affects the amount of benefits you get. If you are eligible for:

(1) Cash assistance, your benefits start:

(a) The date we have enough information to make an eligibility decision; or

(b) No later than the thirtieth day for TANF, SFA, PWA, or RCA; or

(c) No later than the forty-fifth day for ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash assistance unless:

(i) You are confined in a Washington state public institution as defined in WAC 388-406-0005 (6)(a) on the forty-fifth day, in which case your benefits will start on the date you are released from confinement; or

(ii) You are approved for ABD cash assistance at the time of your medical care services (MCS) incapacity review as described in WAC 182-508-0160, in which case your benefits will start on the date you provided sufficient medical evidence to establish disability as defined in WAC 388-449-0001.

(2) Basic Food, your benefits start from the date you applied unless:

(a) You are recertified for Basic Food. If you are recertified for Basic Food, we determine the date your benefits start under WAC 388-434-0010;

(b) You applied for Basic Food while living in an institution. If you apply for Basic Food while living in an institution, the date you are released from the institution determines your start date as follows. If you are expected to leave the institution:

(i) Within thirty days of the date we receive your application, your benefits start on the date you leave the institution; or

(ii) More than thirty days from the date we receive your application, we deny your application for Basic Food. You may apply for Basic Food again when your date of release from the institution is closer.

(c) We were unable to process your application within thirty days because of a delay on your part. If you caused the delay, but submit required verification by the end of the second thirty-day period, we approve your benefits starting the date you provide the required verification. We start your benefits from this date even if we denied your application for Basic Food.

(d) We initially denied your application for Basic Food and your assistance unit (AU) becomes categorically eligible (CE) within sixty days from the date you applied. If your AU becoming CE under WAC 388-414-0001 makes you eligible for Basic Food, the date we approve Basic Food is the date your AU became CE.

(e) You are approved for transitional food assistance under chapter 388-489 WAC. We determine the date transitional benefits start as described under WAC 388-489-0015.

(f) You receive transitional food assistance with people you used to live with, and are now approved to receive Basic Food in a different assistance unit:

(i) We must give the other assistance unit ten days notice as described under WAC 388-458-0025 before we remove you from the transitional food assistance benefits.

(ii) Your Basic Food benefits start the first of the month after we remove you from the transitional benefits. For example, if we remove you from transitional benefits on November 30th, you are eligible for Basic Food on December 1st.

(3) Medical assistance, the date your benefits start is stated in chapter 388-416 WAC.

(4) For long-term care, the date your services start is stated in WAC 388-106-0045.

AMENDATORY SECTION (Amending WSR 03-17-066, filed 8/18/03, effective 9/18/03)

WAC 388-408-0005 What is a cash assistance unit? (1) For all sections of this chapter:

(a) **"We"** means the department of social and health services.

(b) **"You"** means a person that is applying for or getting benefits from the department.

(c) **"Assistance unit"** or **"AU"** is the group of people who live together and whose income or resources we count to decide your eligibility for benefits and the amount of benefits you get.

(2) For ((~~GA-U~~)) ABD cash, we decide who is in the AU under WAC ((~~388-408-0010~~)) 388-408-0060.

(3) For TANF, PWA, or SFA, we decide who is in the AU by taking the following steps:

(a) We start with who must be in the AU under WAC 388-408-0015;

(b) We add those you choose to have in the AU under WAC 388-408-0025; and

(c) We remove those who are not allowed in the AU under WAC 388-408-0020.

NEW SECTION

WAC 388-408-0060 Who is in my assistance unit for aged, blind, or disabled (ABD) cash assistance? (1) If you are an adult that is aged, blind, or likely to be disabled as defined in WAC 388-400-0060 and 388-449-0001, you can be in a ABD cash assistance unit (AU);

(2) If you are married and live with your spouse, we decide who to include in the AU based on who is aged, blind, or likely to be disabled:

(a) If you are both aged, blind, or likely to be disabled as defined in WAC 388-400-0060 and 388-449-0001, we include both of you in the same AU.

(b) If only one spouse is aged, blind, or likely to be disabled, we include only the aged, blind, or likely to be disabled spouse in the AU. We count some of the income of the spouse that is not in the AU as income to the AU under WAC 388-450-0137.

AMENDATORY SECTION (Amending WSR 02-17-030, filed 8/12/02, effective 9/12/02)

WAC 388-416-0010 Medical certification periods for recipients of cash assistance programs. (1) The certification period for medical services begins on the first day of the month of application when the client is determined eligible for cash assistance for one of the following programs:

(a) Temporary assistance for needy families (TANF);

(b) Aged, blind, or disabled (ABD) cash assistance;

(c) Pregnant women assistance (PWA);

(d) Supplemental Security Income (SSI); or

((~~(e)~~)) (e) Refugee assistance.

(2) The certification period for the medical programs associated with the cash programs in subsection (1) of this section continues as long as eligibility for these programs lasts. When a client's cash assistance is terminated, eligibility for medical assistance is continued until eligibility is redetermined as described in WAC ((~~388-418-0025~~)) 182-504-0100.

(3) The certification period for medical can begin up to three months prior to the month of application for clients described in subsection (1) of this section if the conditions in WAC ((~~388-416-0015(6)~~)) 182-504-0015(6) apply.

((~~(4) The certification period for medical care services begins on the date eligibility begins for the following cash assistance programs:~~

~~(a) General assistance for unemployable persons (GA-U); or~~

~~(b) Alcohol and Drug Abuse Treatment and Support Act (ADATSA) programs, when the client is either receiving a grant or waiting for treatment to begin.~~

~~(5) The certification period for medical care services for clients in subsection (4) of this section runs concurrently with the period of eligibility for the client's cash assistance program.~~))

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-424-0010 Citizenship and alien status—Eligibility for TANF, medicaid, and CHIP. (1) To receive temporary assistance for needy families (TANF), medicaid, or children's health insurance program (CHIP) benefits, an individual must meet all other eligibility requirements and be one of the following as defined in WAC 388-424-0001:

(a) A United States (U.S.) citizen;

(b) A U.S. national;

(c) An American Indian born outside the U.S.;

(d) A "qualified alien";

(e) A victim of trafficking; or

(f) A Hmong or Highland Lao.

(2) A "qualified alien" who first physically entered the U.S. before August 22, 1996 as described in WAC 388-424-0006(1) may receive TANF, medicaid, and CHIP.

(3) A "qualified alien" who first physically entered the U.S. on or after August 22, 1996 cannot receive TANF, medicaid, or CHIP for five years after obtaining status as a qualified alien unless the criteria in WAC 388-424-0006(4) ((~~or (5)~~)) are met.

(4) A lawfully present "nonqualified alien" child or pregnant woman as defined in WAC 388-424-0001 who meet residency requirements as defined in WAC 388-468-0005 may receive medicaid or CHIP.

(5) An alien who is ineligible for TANF, medicaid or CHIP because of the five-year bar or because of their immigration status may be eligible for:

(a) Emergency benefits as described in WAC 388-436-0015 (consolidated emergency assistance program) and WAC 388-438-0110 (alien medical program); or

(b) State-funded cash or chemical dependency benefits as described in WAC 388-424-0015 (state family assistance (SFA), ((~~disability lifeline (DL)~~)) aged, blind, or disabled (ABD) cash, and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA)), and medical benefits as described in WAC ((~~388-424-0016~~)) 182-503-0532; or

(c) Pregnancy medical benefits for noncitizen women as described in WAC 388-462-0015(3); or

(d) State-funded apple health for kids as described in WAC 388-505-0210(5).

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-424-0015 Immigrant eligibility restrictions for the state family assistance, ((~~general assistance~~)) ABD cash, PWA, and ADATSA programs. (1) To receive state family assistance (SFA) benefits, you must be:

(a) A "qualified alien" as defined in WAC 388-424-0001 who is ineligible for TANF due to the five-year bar as described in WAC 388-424-0006(3); or

(b) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 388-468-0005, including a noncitizen American Indian who does not meet the criteria in WAC 388-424-0001.

(2) To receive ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash or pregnant women assistance (PWA) benefits, you must be ((~~ineligible for the TANF, SFA, or SSI program for a reason other than failure to cooperate with program requirements, and belong to one of the following groups as defined in WAC 388-424-0001~~)):

(a) A U.S. citizen;

(b) A U.S. national;

(c) An American Indian born outside the U.S.;

(d) A "qualified alien" or similarly defined lawful immigrant such as victim of trafficking as defined in WAC 388-424-0001; or

(e) A nonqualified alien ((~~who meets the Washington state residency requirements as listed in WAC 388-468-0005~~)) described in WAC 388-424-0001 who:

(i) Has verified their intent to stay in the United States indefinitely; and

(ii) The United States Immigration and Customs Enforcement is not taking steps to enforce their departure.

(3) To receive ADATSA benefits, you must belong to one of the following groups as defined in WAC 388-424-0001:

(a) A U.S. citizen;

(b) A U.S. national;

(c) An American Indian born outside the U.S.;

(d) A "qualified alien" or similarly defined lawful immigrant such as victim of trafficking; or

(e) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 388-468-0005.

AMENDATORY SECTION (Amending WSR 11-02-037, filed 12/29/10, effective 2/1/11)

WAC 388-436-0030 How does my eligibility for other possible cash benefits impact my eligibility for CEAP ((~~depends on other possible cash benefits.~~))? (1) You are

ineligible for CEAP if you, or a household member, are eligible for any of the following programs:

(a) TANF or SFA, unless the family has had its case grant terminated due to WAC 388-310-1600 ((~~within the last six months~~));

(b) Pregnant women assistance (PWA);

(c) RCA;

((~~(c) Disability lifeline (DL)~~)) (d) Aged, blind, or disabled (ABD) cash;

((~~(d)~~)) (e) Supplemental Security Income (SSI);

((~~(e)~~)) (f) Medical assistance for those applicants requesting help for a medical need;

((~~(f)~~)) (g) Food assistance for those applicants requesting help for a food need;

((~~(g)~~)) (h) Housing assistance from any available source for those applicants requesting help for a housing need;

((~~(h)~~)) (i) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(2) The department may require the applicant, or anyone in the assistance unit, to apply for and take any required action to receive benefits from programs described in the above subsection (1)(a) through (h).

(3) The department may not authorize CEAP benefits to any household containing a member who is:

(a) Receiving cash benefits from any of the following programs:

(i) TANF/SFA;

(ii) PWA;

(iii) RCA;

((~~(iii)~~)) (iv) DCA; or

((~~(iv) DL~~)) (v) ABD cash.

(b) Receiving reduced cash benefits for failure to comply with program requirements of TANF/SFA, or RCA.((~~.~~))

(4) The department may authorize CEAP to families reapplying for TANF/SFA who are not eligible for TANF cash benefits under WAC 388-310-1600 until they complete the four week participation requirement.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 05-21-100, filed 10/18/05, effective 11/18/05)

WAC 388-442-0010 How does being a fleeing felon impact my eligibility for benefits? (1) You are a **fleeing felon** if you are fleeing to avoid prosecution, custody, or confinement for a crime or an attempt to commit a crime that is considered a felony in the place from which you are fleeing.

(2) If you are a fleeing felon, or violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision, you are not eligible for TANF/SFA, ((~~GA~~)) PWA, ABD cash, or Basic Food benefits.

NEW SECTION

WAC 388-449-0001 What are the disability requirements for the aged, blind, or disabled (ABD) program? For the purposes of this chapter, "we" and "us" refer to the department of social and health services.

"You" means the applicant or recipient.

"Disabled" is defined by the Social Security Administration for supplemental security income (SSI) as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

"Physical impairment" means a diagnosable physical illness.

"Mental impairment" means a diagnosable mental disorder. We exclude any diagnosis of or related to alcohol or drug abuse or addiction.

(1) We determine if you are likely to be disabled when:

(a) You apply for ABD cash benefits;

(b) You become employed;

(c) You obtain work skills by completing a training program; or

(d) We receive new information that indicates you may be employable.

(2) We determine you are likely to be disabled if:

(a) You are determined to meet SSA disability criteria by the Social Security Administration (SSA);

(b) You are determined to meet SSA disability criteria by disability determination services (DDDS) based on the most recent DDDS determination;

(c) The Social Security Administration (SSA) stops your supplemental security income (SSI) payments solely because you are not a citizen;

(d) You are eligible for long-term care services from aging and disability services administration for a medical condition that is expected to last twelve months or more or result in death; or

(e) You are approved through the sequential evaluation process (SEP) defined in WAC 388-449-0005 through 388-449-0100. The SEP is the sequence of five steps. Step 1 considers whether you are currently working. Steps 2 and 3 consider medical evidence and whether you are likely to meet a listed impairment under Social Security's rules. Steps 4 and 5 consider your residual functional capacity and vocational factors such as age, education, and work experience in order to determine your ability to do your past work or other work.

(3) If you have a physical or mental impairment and you are impaired by alcohol or drug addiction and do not meet the other disability criteria in subsection (2)(a) through (d) above, we decide if you are eligible for ABD cash by applying the sequential evaluation process described in WAC 388-449-0005 through 388-449-0100. You aren't eligible for ABD cash benefits if you are disabled primarily because of alcoholism or drug addiction.

(4) In determining disability, we consider only your ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: sitting, standing, walking, lifting, carrying, handling, and other physical functions (including manipulative or postural functions such as pushing, pulling, reaching, handling, stooping, or crouching), seeing, hearing, communicating, remembering, under-

standing and following instructions, responding appropriately to supervisors and coworkers, tolerating the pressures of a work setting, maintaining appropriate behavior, and adapt to changes in a routine work setting.

(5) We determine you are not likely to meet SSI disability criteria if SSA denied your application for SSI or Social Security Disability Insurance (SSDI) based on disability in the last twelve months unless:

(a) You file a timely appeal with SSA;

(b) SSA decides you have good cause for a late appeal; or

(c) You give us medical evidence of a potentially disabling condition that SSA did not consider or that your condition has deteriorated; and

(d) You give us proof that SSA denied your request to reconsider your claim.

NEW SECTION

WAC 388-449-0005 Sequential evaluation process step 1—How does the department determine if you are performing substantial gainful employment? We deny disability if you are engaging in substantial gainful activity (SGA) when you apply for aged, blind, or disabled (ABD) benefits. "Substantial gainful activity" means you are performing, in a regular and predictable manner, an activity usually done for pay or profit.

(1) You must be earning less than the SGA standard as defined by the Social Security Administration (SSA) to be eligible for ABD cash, unless you work:

(a) Under special conditions that go beyond the employer providing reasonable accommodation, such as in a sheltered workshop; or

(b) Occasionally or part-time because your impairment limits the hours you are able to work compared to unimpaired workers in the same job as verified by your employer.

NEW SECTION

WAC 388-449-0010 What evidence do we consider to determine disability? To determine whether a medically determinable impairment exists, we consider medical evidence from "acceptable medical sources." "Acceptable medical sources" include:

(1) For a physical impairment, a health professional licensed in Washington State or where the examination was performed:

(a) A physician, which includes:

(i) Medical doctor (M.D.);

(ii) Doctor of osteopathy (D.O.);

(iii) Doctor of optometry (O.D.) for visual disorders;

(iv) Doctor of podiatry (D.P.) for foot disorders; and

(v) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only.

(2) For a mental impairment, professionals licensed in Washington State or where the examination was performed:

(a) A psychiatrist; or

(b) A psychologist.

(3) We accept medical evidence of how your impairment(s) affect your ability to function from treating medical sources once a diagnosis of a medically determinable impairment has been established by an "acceptable medical source" listed in (1) and (2) above:

(a) All medical professionals listed in (1) and (2) above;

(b) A physician who is currently treating you for a mental impairment;

(c) A physician's assistant who is currently treating you for a physical impairment; and

(d) An advanced nurse practitioner who is treating you for a condition within their certification.

(4) "Other evidence" means information from other sources not listed in subsection (1), (2), or (3) of this section who can provide supporting documentation of functioning for impairments established by acceptable medical sources in subsections (1) or (2) of this section. Other sources include public and private agencies, nonmedical sources such as schools, parents and caregivers, social workers and employers, and other practitioners such as naturopaths, chiropractors, and audiologists.

NEW SECTION

WAC 388-449-0015 What medical evidence do I need to provide? You must give us medical evidence of your impairment(s) and how they affect your ability to perform regular and continuous work activity. Medical evidence must be in writing and be clear, objective, and complete.

(1) Objective evidence for physical impairments means:

(a) Laboratory test results;

(b) Pathology reports;

(c) Radiology findings including results of X rays and computer imaging scans;

(d) Clinical findings, including but not limited to ranges of joint motion, blood pressure, temperature or pulse, and documentation of a physical examination; and

(e) Hospital history and physical reports and admission and discharge summaries; or

(f) Other medical history and physical reports related to your current impairments.

(2) Objective evidence for mental impairments means:

(a) Clinical interview observations, including objective mental status exam results and interpretation.

(b) Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) Hospital, outpatient and other treatment records related to your current impairments.

(d) Testing results, if any, including:

(i) Description and interpretation of tests of memory, concentration, cognition or intelligence; or

(ii) Interpretation of medical tests to identify or exclude a connection between the mental impairment and physical illness.

(3) Medical evidence sufficient for a disability determination must be from a medical professional described in WAC 388-449-0010 and must include:

(a) A diagnosis for the impairment, or impairments, based on an examination performed by an acceptable medical source defined in WAC 388-449-0010 within five years of application;

(b) A clear description of how the impairment relates to your ability to perform the work-related activities listed in WAC 388-449-0005;

(c) Documentation of how long a condition has impaired your ability to perform work related activities;

(d) A prognosis, or written statement of how long an impairment will impair your ability to perform work related activities; and

(e) A written statement from a medical professional (defined in WAC 388-449-0010) describing what you are capable of doing despite your impairment (medical source statement) based on an examination performed within ninety days of the date of application or forty-five days before the month of disability review.

(4) We consider documentation in addition to objective evidence to support the acceptable medical source or treating provider's opinion that you are unable to perform substantial gainful employment, such as proof of hospitalization.

(5) When making a disability decision, we don't use your report of symptoms as evidence unless objective evidence shows there is an impairment that could reasonably be expected to produce those symptoms.

(6) We don't use symptoms related to substance abuse or a diagnosis of chemical dependency when determining disability if we have evidence substance use is material to your impairment(s).

(7) We consider substance use to be material to your impairment(s) if you are disabled primarily because of drug or alcohol abuse or addiction.

(8) If your impairment will persist at least sixty days after you stop using drugs or alcohol, we do not consider substance use to be material to your impairment.

(9) If you can't obtain medical evidence sufficient for us to determine if you are likely to be disabled without cost to you, and you meet the other eligibility conditions in WAC 388-400-0060, we pay the costs to obtain objective evidence based on published payment limits and fee schedules.

(10) We determine the likelihood of disability based solely on the objective information we receive. We are not obligated to accept another agency's or person's decision that you are disabled or unemployable.

NEW SECTION

WAC 388-449-0020 How does the department evaluate functional capacity for mental health impairments? If you have a mental impairment, we evaluate ability to function in a work setting based on an objective clinical assessment from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC 388-449-0010. Functioning means your ability to perform typical tasks that would be required in a routine job setting and your ability to interact effectively while working.

(1) We evaluate cognitive and social functioning by assessing your ability to:

(a) Understand, remember, and persist in tasks by following very short and simple instructions.

(b) Understand, remember, and persist in tasks by following detailed instructions.

(c) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances without special supervision.

(d) Learn new tasks.

(e) Perform routine tasks without special supervision.

(f) Adapt to changes in a routine work setting.

(g) Make simple work-related decisions.

(h) Be aware of normal hazards and take appropriate precautions.

(i) Ask simple questions or request assistance.

(j) Communicate and perform effectively in a work setting with public contact.

(k) Communicate and perform effectively in a work setting with limited public contact.

(l) Complete a normal workday and workweek without interruptions from psychologically based symptoms.

(m) Set realistic goals and plan independently.

(n) Maintain appropriate behavior in a work setting.

NEW SECTION

WAC 388-449-0030 How does the department evaluate functional capacity for physical impairments? If you have a physical impairment, we evaluate your ability to work based on objective medical evidence from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC 388-449-0010.

(1) **"Exertion level"** means having strength, flexibility, and mobility to lift, carry, stand or walk as needed to fulfill job duties in the following work levels. For this section, "occasionally" means less than one-third of the time and "frequently" means one-third to two-thirds of the time.

The following table is used to determine your exertion level. Included in this table is a strength factor, which is your ability to perform physical activities, as defined in Appendix C of the Dictionary of Occupational Titles (DOT), Revised Edition, published by the U.S. Department of Labor as posted on the Occupational Information Network (O*NET).

If you are able to:	Then we assign this exertion level
(a) Lift ten pounds maximum and frequently lift or carry lightweight articles. Walking or standing only for brief periods.	Sedentary
(b) Lift twenty pounds maximum and frequently lift or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday. Sitting and using pushing or pulling arm or leg movements most of the day.	Light

If you are able to:	Then we assign this exertion level
(c) Lift fifty pounds maximum and frequently lift or carry up to twenty-five pounds.	Medium
(d) Lift one hundred pounds maximum and frequently lift or carry up to fifty pounds.	Heavy

(2) **"Exertional limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. We consider any exertional limitations when we determine your ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility you can apply to work-related activities. We consider the effect of the physical impairment on the ability to perform work-related activities when the severity of the physical impairment(s) is moderate, marked, or severe. We determine functional physical capacity based on your exertional and nonexertional limitations. All limitations must be substantiated the medical evidence and directly related to the diagnosed impairment(s).

(4) **"Nonexertional physical limitation"** means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Nonexertional restrictions may include, among other things, your inability to work at heights or in an area where you would be exposed to chemicals.

(5) **"Functional limitations"** means a restriction on work activities related to unrelieved pain or the effects of prescribed medication. We determine your functional limitations based on objective documentation from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC 388-449-0010. We evaluate functioning by assessing your ability to:

(a) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.

(b) Perform routine tasks without undue supervision.

(c) Make simple work-related decisions.

(d) Be aware of normal hazards and take appropriate precautions.

(e) Ask simple questions or request assistance.

(f) Maintain appropriate behavior in a work setting.

NEW SECTION

WAC 388-449-0035 How does the department assign severity ratings to my impairment? (1) "Severity rating" is a rating of the extent of your impairment and how it impacts your ability to perform basic work activities. The following chart provides a description of limitations on work activities and the severity ratings assigned to each.

Effect on Work Activities	Degree of Impairment	Numerical Value
(a) There is no effect on your performance of one or more basic work-related activities.	None	1
(b) There is no significant limit on your performance of one or more basic work-related activities.	Mild	2
(c) There are significant limits on your performance of one or more basic work-related activities.	Moderate	3
(d) There are very significant limits on your performance of one or more basic work-related activities.	Marked	4
(e) You are unable to perform basic work-related activities.	Severe	5

(2) We use the description of how your condition impairs your ability to perform work activities given by the acceptable medical source or your treating provider, and review other evidence you provide, to establish severity ratings when the impairments are supported by, and consistent with, the objective medical evidence.

(3) A contracted doctor reviews your medical evidence and the ratings assigned to your impairment when:

(a) The medical evidence indicates functional limitations consistent with at least a moderate physical or mental health impairment;

(b) Your impairment is expected to last, twelve months or more with available medical treatment; and

(c) You are not an active ABD recipient previously determined likely to be disabled as defined in WAC 388-449-0010 through 388-449-0100.

(4) The contracted doctor reviews your medical evidence, severity rating, and functional assessment to determine whether:

(a) The Medical evidence is objective and sufficient to support the findings of the provider;

(b) The description of the impairment(s) is supported by the medical evidence; and

(c) The severity rating and assessment of functional limitations assigned by DSHS are consistent with the medical evidence.

(5) If the medical provider's description of your impairment(s) is not consistent with the objective evidence, we will assign a severity rating and functional limitations consistent with the objective medical evidence, and clearly describe why we rejected the medical evidence provider's opinion.

NEW SECTION

WAC 388-449-0040 How does the department determine the severity of mental impairments? If you are diagnosed with a mental impairment by an acceptable medical source described in WAC 388-449-0010, we use information from medical sources described in WAC 388-449-0010 to determine how the impairment limits work-related activities.

(1) We review the following psychological evidence to determine the severity of your mental impairment:

(a) Psychosocial and treatment history records;

(b) Clinical findings of specific abnormalities of behavior, mood, thought, orientation, or perception;

(c) Results of psychological tests; and

(d) Symptoms observed by the examining practitioner, and other evidence, that show how your impairment affects your ability to perform basic work-related activities.

(2) We exclude diagnosis and symptoms related to alcohol or substance abuse or addiction, if we have evidence substance use is material to your impairment.

(3) If you are diagnosed with mental retardation, the diagnosis must be based on the Wechsler Adult Intelligence Scale (WAIS). The following test results determine the severity rating:

Intelligence Quotient (IQ) Score	Severity Rating
85 or above	None (1)
71 to 84	Moderate (3)
60 to 70	Marked (4)
59 or lower	Severe (5)

(4) If you are diagnosed with a mental impairment with physical causes, we assign a severity rating based on the most severe of the following four areas of impairment:

(a) Short term memory impairment;

(b) Perceptual or thinking disturbances;

(c) Disorientation to time and place; or

(d) Labile, shallow, or coarse affect.

(5) We base the severity of an impairment diagnosed as a mood, thought, memory, or cognitive disorder on a clinical assessment of the intensity and frequency of symptoms that:

(a) Affect your ability to perform basic work related activities; and

(b) Are consistent with a diagnosis of a mental impairment as listed in the most recent published edition of the Diagnostic and Statistical Manual of Mental Disorders.

(6) The Global Assessment of Functioning (GAF) is a numeric scale (0 through 100) used to rate the social, occupational, and psychological functioning of adults.

(7) We base the severity rating for a functional mental impairment on accumulated severity ratings for the symptoms in subsection (5) (a) of this section as follows:

Symptom Ratings or Condition	Severity Rating
(a) The objective evidence and global assessment of functional score are consistent with a significant limitation on performing one or more basic work activities.	Moderate (3)
(b) You are diagnosed with a functional disorder with psychotic features. (c) You have had two or more hospitalizations for psychiatric reasons in the past two years. (d) You have had more than six months of continuous psychiatric inpatient or residential treatment in the past two years. (e) The objective evidence and global assessment of functioning score are consistent with a very significant limitations on ability to perform one or more basic work activities.	Marked (4)
(f) The objective evidence and global assessment of functioning score are consistent with the inability to perform work activities.	Severe (5)

(8) If you are diagnosed with any combination of mental retardation, mental impairment with physical causes, or functional mental impairment, we assign a severity rating as follows:

Condition	Severity Rating
(a) Two or more disorders with moderate severity (3) ratings; or (b) One or more disorders rated moderate severity (3), and one rated marked severity (4).	Marked (4)
(c) Two or more disorders rated marked severity (4).	Severe (5)

NEW SECTION

WAC 388-449-0045 How does the department determine the severity of physical impairments? We must decide if your physical impairment is serious enough to significantly limit your ability to perform substantial gainful activity. "Severity of a physical impairment" means the degree that an impairment restricts you from performing basic work-related activities (see WAC 388-449-0005). Severity ratings range from none to severe. We will assign severity ratings according to the table in WAC 388-449-0035.

We assign to each physical impairment a severity rating that is supported by medical evidence.

NEW SECTION

WAC 388-449-0050 How does the department determine the severity of multiple impairments? (1) If you have more than one impairment, we decide the overall severity rating by determining if your impairments have a combined effect on your ability to be gainfully employed. Each diagno-

sis is grouped by affected organ or function into one of thirteen body systems. The thirteen body systems consist of:

(a) Musculo-skeletal;
(b) Special senses and speech;
(c) Respiratory;
(d) Cardiovascular;
(e) Digestive;
(f) Genito-urinary;
(g) Hematological;
(h) Skin;
(i) Endocrine;
(j) Neurological;
(k) Mental disorders;
(l) Malignant neoplastic; and
(m) Immune system.

(2) We follow these rules when there are multiple impairments:

(a) We group each diagnosis by body system.

(b) When you have two or more diagnosed impairments that limit work activities, we assign an overall severity rating as follows:

Your Condition	Severity Rating
(i) All impairments are mild and there is no cumulative effect on basic work activities.	Mild
(ii) All impairments are mild and there is a cumulative effect on basic work activities.	Moderate
(iii) Two or more impairments are of moderate severity and there is a cumulative effect on basic work activities.	Marked
(iv) Two are more impairments are of marked severity.	Severe

NEW SECTION

WAC 388-449-0060 Sequential evaluation process step II—How does the department review medical evidence to determine if I am eligible for benefits? When we receive your medical evidence, we review it to determine if it is sufficient to decide whether your circumstances meet disability requirements.

(1) We require written medical evidence to determine disability. The medical evidence must:

(a) Contain sufficient information as described under WAC 388-449-0015;

(b) Be written by an acceptable medical source or treating provider described in WAC 388-449-0010;

(c) Document the existence of a potentially disabling condition by an acceptable medical source described in WAC 388-449-0010; and

(d) Document the impairment is expected to last twelve continuous months or more with available treatment, or result in death.

(2) If the information received isn't clear, we may require more information before we determine whether you meet ABD disability requirements. As examples, we may require you to get more medical tests or be examined by a medical specialist.

(3) We deny disability if:

(a) We don't have evidence that your impairment is of at least moderate severity as defined in WAC 388-449-0035, 388-449-0040, 388-449-0045, or 388-449-0050;

(b) Your impairment isn't expected to last twelve or more months with available treatment or result in death; or

(c) We have evidence drug or alcohol abuse or addiction is material to your impairment(s).

NEW SECTION

WAC 388-449-0070 Sequential evaluation process step III—How does the department determine if you meet SSA listing of impairments criteria? We approve disability when we determine your impairment(s) meet a listing described in appendix 1 to Subpart P of Part 404 within Title 20 of the Code of Federal Regulations.

NEW SECTION

WAC 388-449-0080 Sequential evaluation process step IV—How does the department evaluate if I am able to perform relevant past work? (1) If we neither deny disability at Step 1 or 2 nor approve it at Step 3, we consider our assessment of your physical and/or mental functional capacity, per WAC 388-449-0020 and 388-449-0030, to determine if you can do work you have done in the past.

(2) We evaluate your work experience to determine if you have relevant past work and transferable skills. "Relevant past work" means work:

(a) Defined as substantial gainful activity per WAC 388-449-0005;

(b) You have performed in the past fifteen years; and

(c) You performed long enough to acquire the knowledge and skills necessary to continue performing the job. You must meet the specific vocational preparation level as defined in Appendix C of the Dictionary of Occupational Titles.

(3) For each relevant past work situation, we compare:

(a) The exertional, nonexertional, and skill requirements of the job based on the Appendix C of the Dictionary of Occupational Titles; and

(b) Current cognitive, social, exertional, and nonexertional factors that significantly limit your ability to perform past work.

(4) We deny disability when we determine that you are able to perform any of your relevant past work.

(5) We approve disability when you are fifty-five years of age or older and don't have the physical, cognitive, or social ability to perform past work.

NEW SECTION

WAC 388-449-0100 Sequential evaluation process step V—How does the department evaluate if I can perform other work when determining disability? If we decide you cannot do work that you have done before, we then decide if you have the residual functional capacity to perform other work.

(1) We evaluate education in terms of formal schooling or other training to acquire skills that enable you to meet job requirements. We classify education as:

If you	Then your education level is
(a) Can't read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b) Have no formal schooling or vocational training beyond the sixth grade.	Marginal education
(c) Have no formal schooling or vocational training beyond the eleventh grade; or (d) Had participated in special education in basic academic classes of reading, writing or mathematics in high school.	Limited education
(e) Have received a high school diploma or general equivalency degree (GED) and don't meet the special education definition in (d) above; or (f) Have received skills training and were awarded a certificate, degree or license.	High school and above level of education

(2) We approve disability when you have a moderate, marked, or severe physical health impairment and you meet the criteria below:

Exertional level	Your age	Your education level	Work history	Nonexertional and functional limitations
Restricted to less than sedentary	Any age	Any level	Does not apply	Does not apply
Restricted to sedentary	Any age	Any level	Does not apply	You have nonexertional or functional impairments that preclude all sedentary work
Restricted to sedentary	Fifty and older	Any level	Does not apply	Does not apply
Restricted to sedentary	Forty-five and older	Marginal education, illiterate, or unable to communicate in English	Unskilled or none	Does not apply
Restricted to light	Any age	Any level	Does not apply	You have nonexertional or functional impairments that preclude all sedentary work
Restricted to light	Fifty and older	Marginal education or unable to communicate in English	Does not apply	Does not apply

(3) We approve disability when you have a mental impairment, with an overall severity of moderate, marked, or severe, and we have documentation, including a mental status exam (MSE) per WAC 388-449-0040, that demonstrate social or cognitive factors, as described in WAC 388-448-0020 that result in a substantial loss of ability to perform basic mental demands of competitive unskilled work as follows:

Your age	Your education	Work history	Social restrictions
Any age	Any level	Any level	Substantial loss of the ability to: • Understand, remember, and persist in tasks by following very short and simple instructions; • Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances without special supervision; • Perform routine tasks without special supervision; • Adapt to changes in a routine work setting; • Make simple work-related decisions; • Be aware of normal hazards and take appropriate precautions; • Ask simple questions or request assistance; • Communicate and perform effectively in a work setting; • Complete a normal workday and workweek without interruptions from psychologically based symptoms; or • Maintain appropriate behavior in a work setting.
Fifty and older	Any level	Any level	Substantial loss of in the ability to: • Understand, remember, and persist in tasks by following detailed complex instructions; • Set realistic goals and plan independently; or • Learn new tasks.

(4) **"Substantial loss of the ability to perform basic work activity"** means the inability to perform the particular activity in regular competitive employment or outside of a sheltered work setting.

(5) We approve disability when you have both mental and physical impairments, with an overall severity that is moderate, marked, or severe, and we have documentation, including a mental status exam (MSE) per WAC 388-449-0040, that demonstrate social or cognitive factors, as described in WAC 388-448-0020 that interfere with working as follows:

Your age	Your education level	Exertional level	Social restrictions	Other vocational factors
Any age	Any level	Restricted to light or less	You are significantly impaired in your ability to: • Communicate and perform effectively in a work setting; or • Maintain appropriate behavior in a work setting.	No transferable skills to work level
Fifty or older	Limited education or unable to communicate in English	Restricted to light or less	Does not apply	No transferable skills to work level
Any age	Marginal education, illiterate, or unable to communicate in English	Restricted to medium or less	You are significantly impaired in your ability to: • Communicate and perform effectively in a work setting with limited public contact; or • Maintain appropriate behavior in a work setting.	No transferable skills to work level

(6) If you don't meet the criteria listed above, and there are jobs you can do, we will find you are able to perform other work and take the following actions:

(a) Deny disability; and

(b) Give you examples of jobs you can do despite your impairments(s).

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

NEW SECTION

WAC 388-449-0150 When does my eligibility for aged, blind, or disabled (ABD) cash benefits end? (1) The maximum period of eligibility for ABD cash is twenty-four months before we must review additional medical evidence. If you remain on ABD cash at the end of the twenty-four month period, we determine your eligibility using current medical evidence.

(2) If your application for SSI is denied:

(a) We review your eligibility for the ABD cash program;

(b) We stop your benefits if you do not provide proof you have filed an appeal with SSA within sixty days of a SSI denial for not being disabled.

(3) We stop your benefits after the final decision on your application for SSI/SSA benefits or if you fail to follow through with any part of the SSI/SSA application or appeals process.

NEW SECTION

WAC 388-449-0200 Am I eligible for cash assistance for aged, blind, or disabled (ABD) while waiting for supplemental security income (SSI)? (1) You may receive ABD benefits while you are waiting to receive supplemental security income (SSI) benefits only when you:

(a) Have filed your SSI application with the Social Security Administration (SSA), follow through with SSA directions and requirements to process your application including keeping all interview and consultative examination appointments, and do not withdraw your application;

(b) Agree to assign the initial or reinstated SSI payment to us provided under WAC 388-449-0210;

(c) Are otherwise eligible according to WAC 388-400-0060; and

(d) Meet disability criteria listed in WAC 388-449-0001.

(2) To demonstrate your impairments are disabling despite medical treatment, you must participate in medical treatment for the impairments that keep you from working, unless you meet one of the following good cause reasons:

(a) The treatment provider has identified a risk that the treatment may cause further limitations or loss of a function or an organ and you are not willing to take that risk; or

(b) We determine that treatment is not available because you can't obtain it without cost to you.

(3) If you refuse or fail to participate in medical treatment without good cause, your benefits will end until you reapply and provide proof you are pursuing treatment as recommended.

NEW SECTION

WAC 388-449-0210 What is interim assistance and how do I assign it to the department? The ABD and SSI programs both provide cash assistance to meet your basic needs. You cannot receive this assistance for the same time period from both programs. When you are approved for or reinstated on SSI, you may receive a retroactive payment. When we made GA, DL, or ABD payments to you or on your behalf for the same time period, you must assign your interim assistance to repay us.

(1) **"Assign"** means that you sign a written authorization for the Social Security Administration (SSA) to send the SSI retroactive payment to us.

(2) **"Interim assistance"** means the monetary value of benefits we paid to you or on your behalf during:

(a) The time between your SSI application date and the month recurring SSI payments begin; or

(b) The period your SSI payments were suspended or terminated, and later reinstated.

NEW SECTION

WAC 388-449-0220 How does alcohol or drug dependence affect my eligibility for the ABD cash and pregnant women assistance programs? (1) You must complete a chemical dependency assessment when we have information that indicates you may be chemically dependent.

(2) You must accept an assessment referral and participate in drug or alcohol treatment if a certified chemical dependency counselor indicates a need for treatment, unless you meet one of the following good cause reasons:

(a) We determine that your physical or mental health impairment prevents you from participating in treatment.

(b) The outpatient chemical dependency treatment you need isn't available in the county you live in.

(c) You need inpatient chemical dependency treatment at a location that you can't reasonably access.

(3) If you refuse or fail to complete an assessment or treatment without good cause, your benefits will end until you provide proof you are pursuing an assessment or treatment as required.

NEW SECTION

WAC 388-449-0225 Am I required to participate in vocational rehabilitation services if I receive ABD cash grant? You must participate in vocational rehabilitation services through the division of vocational rehabilitation (DVR) if you are determined to be eligible for DVR services.

AMENDATORY SECTION (Amending WSR 10-15-069, filed 7/16/10, effective 8/16/10)

WAC 388-450-0040 Native American benefits and payments. This section applies to TANF/SFA, RCA, ((~~GA~~)) PWA, ABD cash, medical, and food assistance programs.

(1) The following types of income are not counted when a client's benefits are computed:

(a) Up to two thousand dollars per individual per calendar year received under the Alaska Native Claims Settlement Act, P.L. 92-203 and 100-241;

(b) Income received from Indian trust funds or lands held in trust by the Secretary of the Interior for an Indian tribe or individual tribal member. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(c) Income received from Indian judgement funds or funds held in trust by the Secretary of the Interior distributed per capita under P.L. 93-134 as amended by P.L. 97-458 and 98-64. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(d) Up to two thousand dollars per individual per calendar year received from leases or other uses of individually owned trust or restricted lands, P.L. 103-66;

(e) Payments from an annuity fund established by the Puyallup Tribe of Indians Settlement Act of 1989, P.L. 101-41, made to a Puyallup Tribe member upon reaching twenty-one years of age; and

(f) Payments from the trust fund established by the P.L. 101-41 made to a Puyallup Tribe member.

(2) Other Native American payments and benefits that are excluded by federal law are not counted when determining a client's benefits. Examples include but are not limited to:

(a) White Earth Reservation Land Settlement Act of 1985, P.L. 99-264, Section 16;

(b) Payments made from submarginal land held in trust for certain Indian tribes as designated by P.L. 94-114 and P.L. 94-540;

(c) Payments under the Seneca Nation Settlement Act, P.L. 101-503; and

(d) For medical assistance, receipt of money by a member of a federally recognized tribe from exercising federally protected rights or extraction of protected resources, such as fishing, shell-fishing, or selling timber, is considered conversion of an exempt resource during the month of receipt. Any amounts remaining from the conversion of this exempt resource on the first of the month after the month of receipt will remain exempt if the funds were used to purchase another exempt resource. Any amounts remaining in the form of countable resources (such as in checking or savings accounts) on the first of the month after receipt, will be added to other countable resources for eligibility determinations.

AMENDATORY SECTION (Amending WSR 06-17-017, filed 8/4/06, effective 9/4/06)

WAC 388-450-0045 How do we count income from employment and training programs? This section applies to cash assistance, Basic Food, and medical programs for families, children, and pregnant women.

(1) We treat payments issued under the Workforce Investment Act (WIA) as follows:

(a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.

(b) For Basic Food:

(i) We exclude OJT earnings for children who are eighteen years of age or younger and under parental control as described in WAC 388-408-0035.

(ii) We count OJT earnings as earned income for people who are:

(A) Age nineteen and older; or

(B) Age eighteen or younger and not under parental control.

(iii) We exclude all other payments.

(2) We exclude **all** payments issued under the National and Community Service Trust Act of 1993. This includes payments made through the AmeriCorps program.

(3) We treat payments issued under Title I of the Domestic Volunteer Act of 1973, such as VISTA, AmeriCorps Vista, university year for action, and urban crime prevention program as follows:

(a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.

(b) For Basic Food, we count most payments as earned income. We exclude the payments if you:

(i) Received Basic Food or cash assistance at the time you joined the Title I program; or

(ii) Were participating in the Title I program and received an income disregard at the time of conversion to the Food Stamp Act of 1977. We continue to exclude the payments even if you do not get Basic Food every month.

(4) We exclude **all** payments issued under Title II of the Domestic Volunteer Act of 1973. These include:

(a) Retired senior volunteer program (RSVP);

(b) Foster grandparents program; and

(c) Senior companion program.

(5) We count training allowances from vocational and rehabilitative programs as earned income when:

(a) The program is recognized by federal, state, or local governments; and

(b) The allowance is not a reimbursement.

(6) ((~~When GAU clients receive training allowances we allow:~~

~~(a) The earned income incentive and work expense deduction specified under WAC 388-450-0175, when applicable; and~~

~~(b) The actual cost of uniforms or special clothing required for the course as a deduction, if enrolled in a remedial education or vocational training course.~~

~~(7)~~)) We exclude support service payments received by or made on behalf of WorkFirst participants.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0095 Allocating income—General. This section applies to TANF/SFA, RCA, ((~~and GA~~)) PWA, and ABD cash assistance programs.

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit.

(2) In-bound allocation means income possessed by a financially responsible person outside the assistance unit

which is considered available to meet the needs of legal dependents in the assistance unit.

(3) Out-bound allocation means income possessed by a financially responsible assistance unit member which is set aside to meet the needs of a legal dependent outside the assistance unit.

AMENDATORY SECTION (Amending WSR 04-15-057, filed 7/13/04, effective 8/13/04)

WAC 388-450-0100 Allocating income—Definitions. The following definitions apply to the allocation rules for TANF/SFA, RCA, ((~~and GA~~)) PWA, and ABD cash programs:

(1) **"Dependent"** means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) **"Financially responsible person"** means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) A **"disqualified assistance unit member"** means a person who is:

(a) An unmarried pregnant or parenting minor under age eighteen who has not completed a high school education or general education development (GED) certification and is not participating in those educational activities which would lead to the attainment of a high school diploma or GED;

(b) An unmarried pregnant or parenting minor under age eighteen who is not living in a department-approved living situation;

(c) The financially responsible person who does not report to the department within five days of the date it becomes reasonably clear that the absence of a child will exceed ninety days;

(d) A person who has been convicted in federal or state court of having made a fraudulent statement or representation about their place of residence in order to receive assistance from two or more states at the same time as defined in WAC 388-446-0010; and

(e) A person who has been convicted of unlawfully receiving public assistance as defined under WAC 388-446-0005.

(4) **"Ineligible assistance unit member"** means an individual who is:

(a) Ineligible for cash assistance due to the citizenship/alien status requirements in WAC 388-424-0010;

(b) Ineligible to receive assistance under WAC 388-442-0010 for having been convicted after August 21, 1996, under federal or state law, of possession, use or distribution of a controlled substance;

(c) Ineligible to receive assistance under WAC 388-442-0010 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime;

(d) Ineligible to receive assistance under WAC 388-442-0010 for violating a condition of probation or parole which was imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction;

(e) The spouse of a woman who receives cash benefits from the ((~~GA-S~~)) PWA program; or

(f) The adult parent of a minor parent's child.

NEW SECTION

WAC 388-450-0112 Does the department allocate the income of an ABD cash client to legal dependents? This section applies to the aged, blind, or disabled (ABD) cash assistance program.

(1) The income of an ABD cash client is reduced by the following:

(a) The ABD cash earned income disregard as specified in WAC 388-450-0177; and

(b) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(2) When a ABD cash client in a medical institution, alcohol or drug treatment center, congregate care facility or adult family home has income, the income is countable to meet the client's needs after the income is reduced by the following:

(a) The payment standard amount for the nonapplying spouse and legal dependents living in the home; and

(b) The standard of assistance the client is eligible for while in an alternative care facility.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0115 ((~~Allocating~~)) Does the department allocate the income of a financially responsible person who is excluded from the assistance unit((~~.~~))? This section applies to TANF/SFA, RCA and ((~~GA-S~~)) PWA programs.

The income of a financially responsible person excluded from the assistance unit is available to meet the needs of the assistance unit after the income is reduced by the following:

(1) A ninety dollar work expense deduction from the financially responsible person(s) excluded from the assistance unit who is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0120 ((~~Allocating~~)) Does the department allocate the income of financially responsible parents to a pregnant or parenting minor((~~.~~))? This section applies to TANF/SFA, RCA and ((~~GA-S~~)) PWA programs.

The income of nonapplying financially responsible parent(s) of a pregnant or parenting minor is countable to meet the needs of the minor and the child(ren) after the income is reduced by the following:

(1) A ninety dollar work expense from the financially responsible parent's gross income from employment;

(2) An amount not to exceed the department's standard of need for:

(a) The financially responsible parent and dependent living in the home who are not applying for or receiving cash benefits and not a disqualified individual; and

(b) Court or administratively ordered current or back support for legal dependents.

(3) Spousal maintenance payments made to meet the needs of individuals not living in the home.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0130 ((~~Allocating~~)) Does the department allocate the income of a nonapplying spouse to a caretaker relative((~~.~~))? This section applies to TANF/SFA, PWA, and RCA programs.

(1) The community income of the nonapplying spouse and applying spouse is combined. See WAC 388-450-0005 to determine what income is available as community income.

(2) Subtract a one person payment standard as specified in WAC 388-478-0020.

(3) The remainder is allocated to the caretaker relative.

NEW SECTION

WAC 388-450-0137 Does the department allocate income of an ineligible spouse to an ABD cash client? This section applies to the aged, blind, or disabled (ABD) cash assistance program.

(1) When an ABD cash client is married and lives with the nonapplying spouse, the following income is available to the client:

(a) The remainder of the client's wages, retirement benefits or separate property after reducing the income by:

(i) The ABD cash work incentive deduction, as specified in WAC 388-450-0177; and

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(b) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(i) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents; and

(ii) The payment standard amount as specified under WAC 388-478-0033 which includes ineligible assistance unit members.

(c) One-half of all other community income, as provided in WAC 388-450-0005.

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-450-0156 When am I exempt from deeming? (1) If you meet any of the following conditions, you are **permanently** exempt from deeming and we do not count your sponsor's income or resources against your benefits:

(a) The Immigration and Nationality Act (INA) does not require you to have a sponsor. Immigrants who are not required to have a sponsor include those with the following status with United States Citizenship and Immigration Services (USCIS):

(i) Refugee;

(ii) Parolee;

(iii) Asylee;

(iv) Cuban/Haitian entrant; or

(v) Special immigrant from Iraq or Afghanistan.

(b) You were sponsored by an organization or group as opposed to an individual;

(c) You do not meet the alien status requirements to be eligible for benefits under chapter 388-424 WAC;

(d) You have worked or can get credit for forty qualifying quarters of work under Title II of the Social Security Act. We do not count a quarter of work toward this requirement if the person working received TANF, food stamps, Basic Food, SSI, CHIP, or nonemergency medicaid benefits. We count a quarter of work by the following people toward your forty qualifying quarters:

(i) Yourself;

(ii) Each of your parents for the time they worked before you turned eighteen years old (including the time they worked before you were born); and

(iii) Your spouse if you are still married or your spouse is deceased.

(e) You become a United States (U.S.) Citizen;

(f) Your sponsor is dead; or

(g) If USCIS or a court decides that you, your child, or your parent was a victim of domestic violence from your sponsor and:

(i) You no longer live with your sponsor; and

(ii) Leaving your sponsor caused your need for benefits.

(2) You are exempt from the deeming process while you are in the same AU as your sponsor;

(3) For children and pregnancy medical programs, you are exempt from sponsor deeming requirements.

(4) For Basic Food, you are exempt from deeming while you are under age eighteen.

(5) For state family assistance, ((~~disability lifeline (DL)~~)) aged, blind, or disabled (ABD) cash, pregnant women assistance (PWA), state-funded Basic Food benefits, and state-funded medical assistance for legal immigrants you are exempt from the deeming process if:

(a) Your sponsor signed the affidavit of support more than five years ago;

(b) Your sponsor becomes permanently incapacitated; or

(c) You are a qualified alien according to WAC 388-424-0001 and you:

(i) Are on active duty with the U.S. armed forces or you are the spouse or unmarried dependent child of someone on active duty;

(ii) Are an honorably discharged veteran of the U.S. armed forces or you are the spouse or unmarried dependent child of an honorably discharged veteran;

(iii) Were employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or

(iv) Are a victim of domestic violence and you have petitioned for legal status under the Violence Against Women Act.

(6) If you, your child, or your parent was a victim of domestic violence, you are exempt from the deeming process for twelve months if:

(a) You no longer live with the person who committed the violence; and

(b) Leaving this person caused your need for benefits.

(7) If your AU has income at or below one hundred thirty percent of the federal poverty level (FPL), you are exempt from the deeming process for twelve months. This is called the "indigence exemption." You may choose to use this exemption or not to use this exemption in full knowledge of the possible risks involved. See risks in subsection (9) below. For this rule, we count the following as income to your AU:

(a) Earned and unearned income your AU receives from any source; and

(b) Any noncash items of value such as free rent, commodities, goods, or services you receive from an individual or organization.

(8) If you use the indigence exemption, and are eligible for a federal program, we are required by law to give the United States attorney general the following information:

(a) The names of the sponsored people in your AU;

(b) That you are exempt from deeming due to your income;

(c) Your sponsor's name; and

(d) The effective date that your twelve-month exemption began.

(9) If you use the indigence exemption, and are eligible for a state program, we do not report to the United States attorney general.

(10) If you choose not to use the indigence exemption:

(a) You could be found ineligible for benefits for not verifying your sponsor's income and resources; or

(b) You will be subject to regular deeming rules under WAC 388-450-0160.

AMENDATORY SECTION (Amending WSR 04-03-051, filed 1/15/04, effective 2/15/04)

WAC 388-450-0170 ((~~TANF/SFA earned income incentive and deduction.~~)) Does the department provide an earned income deduction as an incentive for persons who receive TANF/SFA to work? This section applies to TANF/SFA, RCA, PWA, and medical programs for children, pregnant women, and families except as specified under WAC 388-450-0210.

(1) If a client works, the department only counts some of the income to determine eligibility and benefit level.

(2) We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

(3) If you pay for care before we approve your benefits, we subtract the amount you pay for those dependent children or incapacitated adults who get cash assistance with you.

(a) The amount we subtract is:

(i) Prorated according to the date you are eligible for benefits;

(ii) Cannot be more than your gross monthly income; and

(iii) Cannot exceed the following for each dependent child or incapacitated adult:

Dependent Care Maximum Deductions

Hours Worked Per Month	Child Two Years of Age & Under	Child Over Two Years of Age or Incapacitated Adult
0 - 40	$ 50.00	$ 43.75
41 - 80	$ 100.00	$ 87.50
81 - 120	$ 150.00	$ 131.25
121 or More	$ 200.00	$ 175.00

(b) In order to get this deduction:

(i) The person providing the care must be someone other than the parent or stepparent of the child or incapacitated adult; and

(ii) You must verify the expense.

NEW SECTION

WAC 388-450-0177 Does the department offer an income deduction for the ABD cash program as an incentive for clients to work? The department gives a deduction to people who receive income from work while receiving aged, blind, or disabled cash assistance. The deduction applies to aged, blind, or disabled cash benefits only. We allow the following income deduction when we determine the amount of your benefits:

We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

AMENDATORY SECTION (Amending WSR 06-10-034, filed 4/27/06, effective 6/1/06)

WAC 388-460-0020 Who is a protective payee? (1) A protective payee is a person or an employee of an agency who manages client cash benefits to provide for basic needs - housing, utilities, clothing, child care, and food. They may also provide services such as training clients how to manage money.

(2) Clients are assigned to protective payees for the following reasons:

(a) Emergency or temporary situations where a child is left without a caretaker (TANF/SFA) per WAC 388-460-0030;

(b) Mismanagement of money (TANF/SFA, ((~~GA~~)) PWA, ABD cash, or WCCC) per WAC 388-460-0035; or

(c) Pregnant or parenting minors per WAC 388-460-0040.

AMENDATORY SECTION (Amending WSR 02-14-083, filed 6/28/02, effective 7/1/02)

WAC 388-460-0040 When ((~~is~~)) does the department assign a protective payee assigned to TANF/SFA or PWA pregnant or parenting minors? Pregnant or parenting

minors who are not emancipated under court order must be assigned to protective payees if the clients are:

(1) Head of a household;

(2) Under age eighteen;

(3) Unmarried; and

(4) Pregnant or have a dependent child.

AMENDATORY SECTION (Amending WSR 03-20-060, filed 9/26/03, effective 10/27/03)

WAC 388-468-0005 Residency. Subsections (1) through (4) applies to cash, the Basic Food program, and medical programs.

(1) A resident is a person who:

(a) Currently lives in Washington and intends to continue living here permanently or for an indefinite period of time; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) A child under age eighteen is a resident of the state where the child's primary custodian lives.

(4) With the exception of subsection (5) of this section, a client can temporarily be out of the state for more than one month. If so, the client must supply the department with adequate information to demonstrate the intent to continue to reside in the state of Washington.

(5) Basic Food program assistance units who are not categorically eligible do not meet residency requirements if they stay out of the state more than one calendar month.

(6) A client may not receive comparable benefits from another state for the cash and Basic Food programs.

(7) A former resident of the state can apply for the ((~~GA-U~~)) ABD cash program while living in another state if:

(a) The person:

(i) Plans to return to this state;

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in subsection (7)(a) (i)(ii), and (iii) being met, the absence must be:

(i) Enforced and beyond the person's control; or

(ii) Essential to the person's welfare and is due to physical or social needs.

(c) See WAC 388-406-0035, 388-406-0040, and 388-406-0045 for time limits on processing applications.

(8) Residency is not a requirement for detoxification services.

(9) A person is not a resident when the person enters Washington state only for medical care. This person is not eligible for any medical program. The only exception is described in subsection (10) of this section.

(10) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency before entering the facility. The person is considered a resident if they intend to remain permanently or for an indefinite period unless placed in the nursing facility by another state.

(11) For purposes of medical programs, a client's residence is the state:

(a) Paying a state Supplemental Security Income (SSI) payment; or

(b) Paying federal payments for foster or adoption assistance; or

(c) Where the noninstitutionalized individual lives when medicaid eligibility is based on blindness or disability; or

(d) Where the parent or legal guardian, if appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(e) Where a client is residing if the person becomes incapable of determining residential intent after reaching twenty-one years of age; or

(f) Making a placement in an out-of-state institution; or

(g) For any other institutionalized individual, the state of residence is the state where the individual is living with the intent to remain there permanently or for an indefinite period.

(12) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

AMENDATORY SECTION (Amending WSR 05-19-059, filed 9/16/05, effective 10/17/05)

WAC 388-473-0010 What are ongoing additional requirements and how do I qualify? "Ongoing additional requirement" means a need beyond essential food, clothing, and shelter needs and is necessary to help you continue living independently.

(1) We may authorize ongoing additional requirement benefits if you are active in one of the following programs:

(a) Temporary assistance for needy families (TANF), or tribal TANF;

(b) State family assistance (SFA);

(c) Pregnant women assistance (PWA);

(d) Refugee cash;

((~~(d) General assistance cash~~)) (e) Aged, blind, or disabled (ABD) assistance; or

((~~(e)~~)) (f) Supplemental Security Income (SSI).

(2) You apply for an ongoing additional requirement benefit by notifying staff who maintain your cash or medical assistance that you need additional help to live independently.

(3) We authorize ongoing additional requirement benefits only when we determine the item is essential to you. We make the decision based on proof you provide of:

(a) The circumstances that create the need; and

(b) How the need affects your health, safety and ability to continue to live independently.

(4) We authorize ongoing additional requirement benefits by increasing your monthly cash assistance benefit.

(5) We use the following review cycle table to decide when to review your need for the additional benefit(s).

REVIEW CYCLE	
Program	Frequency (Months)
TANF/RCA	6 Months
((~~GA~~)) ABD	12 Months
SSI	24 Months
All	Any time need or circumstances are expected to change

(6) Monthly payment standards for ongoing additional requirements are described under WAC 388-478-0050.

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

AMENDATORY SECTION (Amending WSR 02-11-033, filed 5/7/02, effective 6/7/02)

WAC 388-474-0010 How does being a Supplemental Security Income (SSI) client affect your cash assistance eligibility? (1) If you are married to an SSI recipient but do not get SSI in your own right, you are called an "ineligible spouse."

(2) If you are an ineligible spouse you cannot get the SSI state supplement when you are:

(a) The caretaker relative of a child who receives TANF or SFA; and

(b) Required to be included in the TANF or SFA assistance unit with the child (see WAC 388-408-0015); or

(c) Receiving refugee assistance.

(3) If you are an ineligible spouse and get an SSI state supplement (WAC 388-474-0012), you cannot get ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash assistance.

AMENDATORY SECTION (Amending WSR 02-11-033, filed 5/7/02, effective 6/7/02)

WAC 388-474-0020 What can ((~~a general assistance-unemployable (GA-U)~~)) an aged, blind, or disabled (ABD) cash assistance client expect when Supplemental Security Income (SSI) benefits begin? You ((~~can only get~~)) may only receive assistance to meet your basic needs from one government source at a time (WAC ((~~388-448-0210~~)) 388-449-0210). If you are ((~~a GA-U~~)) an ABD cash client who begins ((~~setting~~)) getting SSI, you should know that:

(1) If you got advance, emergency or retroactive SSI cash assistance for any period where you ((~~got GA-U~~)) received general assistance (GA), disability lifeline (DL), or aged, blind, or disabled (ABD) cash assistance, you must repay the department the amount of ((~~GA-U~~)) cash assistance paid to you for the matching time period.

(2) When you apply for ((~~GA-U~~)) ABD cash you must sign DSHS 18-235(X), interim assistance reimbursement agreement (IARA) to ((~~get GA-U~~)) receive ABD cash assistance.

(3) You cannot use your ((~~GA-U~~)) ABD money to replace money deducted from your SSI check to repay an SSI overpayment.

AMENDATORY SECTION (Amending WSR 10-17-101, filed 8/17/10, effective 9/17/10)

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued. For SSN requirements for immigrants, see WAC 388-424-0009.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) If a person is unable to provide proof of application for a SSN for a newborn:

(i) The newborn can receive Basic Food with the household while effort is being made to get the SSN.

(ii) For the newborn to continue receiving Basic Food benefits; the household must provide proof of application for SSN or the SSN for the newborn, at the next recertification, or within six months following the month the baby is born, whichever is later.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

(a) The consolidated emergency assistance program;

(b) The refugee cash and medical assistance program;

(c) The alien emergency medical program; and

(d) ((~~The state-funded pregnant woman program; and~~

~~(e)~~)) Detoxification services.

NEW SECTION

WAC 388-478-0027 What are the payment standards for pregnant women assistance (PWA)? (1) The payment standards for PWA cash assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	$197

(2) The payment standards for PWA cash assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$120

NEW SECTION

WAC 388-478-0033 What are the payment standards for aged, blind, or disabled (ABD) cash assistance? (1) The payment standards for aged, blind, or disabled (ABD) cash assistance program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment standard
1	$197
2	$248

(2) The payment standards for aged, blind, or disabled (ABD) cash assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$120
2	$152

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-486-0005 Unmarried pregnant or parenting minors—Required living arrangement. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) The following definitions apply to terms used in this section:

(a) "Unmarried" means a person who ((~~have~~)) has never been married or whose marriage has been annulled. It does not include a person who has been divorced or widowed.

(b) "Minor" means a person younger than eighteen years of age.

(c) "Legal guardian" means a court-appointed legal guardian or court-appointed permanent custodian.

(d) "Relative" is a person who is related to the pregnant or parenting minor as defined under RCW 74.15.020(4).

(3) An unmarried pregnant or parenting minor is not eligible for TANF, SFA or ((~~GA-S~~)) PWA unless the person:

(a) Has been emancipated by a court; or

(b) Lives in a home approved by the department and has a protective payee.

(4) The home of a minor's parent, legal guardian, or adult relative may be approved unless:

(a) The minor has no living parent, legal guardian, or adult relative that can be located or those persons do not want the minor to live with them;

(b) The minor or the minor's child is being or has been seriously harmed either physically, emotionally or sexually in the home of the parent, legal guardian, or adult relative;

(c) Substantial evidence exists of an act or failure to act by the parent, legal guardian, or adult relative that presents imminent or serious harm to the minor or the minor's child if they lived there; or

(d) The department determines that it is in the best interest of the minor or the minor's child to waive the requirement of living in the home of a parent, legal guardian, or adult relative.

(5) If the home of a minor's parent, legal guardian, or adult relative is not available or suitable, one of the following alternatives may be approved:

(a) A facility or home licensed under chapter 74.15 RCW that provides a supportive and supervised living arrangement requiring residents to learn parenting skills;

(b) A maternity home;

(c) Other adult-supervised living arrangement; or

(d) The minor's current or proposed living arrangement, if the department determines it is appropriate.

(6) A home that includes the other natural parent of the minor's child or unborn child is never approved if:

(a) The minor is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for rape of a child as set forth in RCW 9A.44.073, 9A.44.076, and 9A.44.079.

(7) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-400-0025	Who is eligible for disability lifeline benefits?
WAC 388-404-0010	Age requirement for GA-U and ADATSA.
WAC 388-408-0010	Who is in my assistance unit for general assistance?
WAC 388-418-0025	Effect of changes on medical program eligibility.
WAC 388-424-0016	Citizenship and alien status—Immigrant eligibility restrictions for state medical benefits.
WAC 388-448-0001	What are the incapacity requirements for general assistance?
WAC 388-448-0010	How do we decide if you are incapacitated?
WAC 388-448-0020	Which health professionals can I go to for medical evidence?
WAC 388-448-0030	What medical evidence do I need to provide?
WAC 388-448-0035	How we assign severity ratings to your impairment.

WAC 388-448-0040	PEP step I—Review of medical evidence required for eligibility determination.
WAC 388-448-0050	PEP step II—How we determine the severity of mental impairments.
WAC 388-448-0060	PEP step III—How we determine the severity of physical impairments.
WAC 388-448-0070	PEP step IV—How we determine the severity of multiple impairments.
WAC 388-448-0080	PEP step V—How we determine your ability to function in a work environment if you have a mental impairment.
WAC 388-448-0090	PEP step V—How we determine your ability to function in a work environment if you have a physical impairment.
WAC 388-448-0100	PEP step VI—How we evaluate capacity to perform relevant past work.
WAC 388-448-0110	PEP step VII—How we evaluate your capacity to perform other work.
WAC 388-448-0120	How we decide how long you are incapacitated.
WAC 388-448-0130	Treatment and referral requirements.
WAC 388-448-0140	When does a person have good cause for refusing or failing to participate in medical treatment or referrals to other agencies?
WAC 388-448-0150	Penalty for refusing or failure to participate in medical treatment or other agency referrals.
WAC 388-448-0160	When do my disability lifeline benefits end?
WAC 388-448-0180	How do we redetermine your eligibility when we decide you are eligible for general assistance expedited medicaid (GAX)?
WAC 388-448-0200	Can I get general assistance while waiting for Supplemental Security Income (SSI)?
WAC 388-448-0210	What is interim assistance and how do I assign it to you?
WAC 388-448-0220	How does alcohol or drug dependence affect my eligibility for disability lifeline?
WAC 388-448-0250	Are there limits on the number of months I may receive disability lifeline benefits?
WAC 388-450-0110	Allocating the income of a GA-U client to legal dependents.
WAC 388-450-0135	Allocating income of an ineligible spouse to a GA-U client.
WAC 388-450-0175	Does the department offer an income deduction for the general assistance program as an incentive for clients to work?
WAC 388-462-0011	Post adoption cash benefit.

AMENDATORY SECTION (Amending WSR 11-16-029, filed 7/27/11, effective 8/27/11)

WAC 388-478-0035 What are the maximum earned income limits for TANF, SFA, PWA and RCA((~~,~~))? To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), ((~~or~~)) refugee cash assistance (RCA), or a pregnant women assistance (PWA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Monthly Earned Income Level
1	$610	6	$1,472
2	770	7	1,700
3	955	8	1,882
4	1,124	9	2,066
5	1,295	10 or more	2,246

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-478-0030	Payment standards for disability lifeline and ADATSA.

WSR 12-06-006
PROPOSED RULES
PUBLIC DISCLOSURE COMMISSION
[Filed February 24, 2012, 9:18 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 12-01-062.

Title of Rule and Other Identifying Information: WAC 390-05-400 Changes to dollar amounts.

Hearing Location(s): Commission Hearing Room, 711 Capitol Way, Room 206, Olympia, WA 98504, on April 26, 2012, at 9:30 a.m.

Date of Intended Adoption: April 26, 2012.

Submit Written Comments to: Lori Anderson, Public Disclosure Commission (PDC), P.O. Box 40908, Olympia, WA 98504-0908, e-mail lori.anderson@pdc.wa.gov, fax (360) 753-1112, by April 24, 2012.

Assistance for Persons with Disabilities: Contact Jana Greer by e-mail jana.greer@pdc.wa.gov or phone (360) 586-0544 or (360) 753-1111.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Insert and adjust contribution limits for city council and mayoral candidates.

Reasons Supporting Proposal: The PDC is required, in even numbered years, to adjust contribution limits based on changes in economic conditions. Effective January 13, 2012, the limits were adjusted by amending WAC 390-05-400. Prior to the 2012 amendment and after the 2010 amendment, contribution limits for city council and mayoral candidates enacted by chapter 206, Laws of 2010. These new limits were not included in the 2012 adjustment. Consequently, all contribution limits set out in RCW 42.17A.405 and 42.17A.-410 were adjusted except for city council and mayoral candidates' contribution limits.

Statutory Authority for Adoption: RCW 42.17A.110 and 42.17A.125.

Statute Being Implemented: RCW 42.17A.405.

Rule is not necessitated by federal law, federal or state court decision.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: The rule amendment conforms to the provisions in RCW 42.17A.125 requiring the commission, at the beginning of each even-numbered calendar year, to adjust dollar amounts in RCW 42.17A.405 based on changes in economic conditions.

Name of Proponent: PDC, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Lori Anderson, 711 Capitol Way, Room 206, Olympia, WA 98504, (360) 664-2737; and Enforcement: Phil Stutzman, 711 Capitol Way, Room 206, Olympia, WA 98504, (360) 664-8853.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The implementation of these rule amendments has minimal impact on small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. The PDC is not an agency listed in subsection (5)(a)(i) of section 201. Further, the PDC does not voluntarily make section 201 applicable to the adoption of these rules pursuant to subsection (5)(a)(i) of section 201, and, to date, the joint administrative rules review committee has not made section 201 applicable to the adoption of these rules.

February 24, 2012
Lori Anderson
Communications and
Training Officer

AMENDATORY SECTION (Amending WSR 12-01-032, filed 12/13/11, effective 1/13/12)

WAC 390-05-400 Changes in dollar amounts. Pursuant to the requirement in RCW 42.17A.125 that the commission biennially revise the dollar amounts found in Initiative 134 and RCW 42.17A.410 to reflect changes in economic conditions, the following revisions are made:

Code Section	Subject Matter	Amount Enacted or Last Revised	2012 Revision
.005	Definition of "Independent Expenditure"	$800	$900
.445(3)	Reimbursement of candidate for loan to own campaign	$4,700	$5,000
.630(1)	Report—		
	Applicability of provisions to		
	Persons who made contributions	$16,000	$18,000
	Persons who made independent expenditures	$800	$900
((~~.405(2)~~)) .405(1)	Contribution Limits—		
	Candidates for state leg. office	$800	$900
	Candidates for county office	$800	$900
	Candidates for other state office	$1,600	$1,800
	Candidates for special purpose districts	$1,600	$1,800
	Candidates for city council office	$800	$900
	Candidates for mayoral office	$800	$900

Code Section	Subject Matter	Amount Enacted or Last Revised	2012 Revision
.405(3)	Contribution Limits—		
	State official up for recall or pol comm. supporting recall—		
	State Legislative Office	$800	$900
	Other State Office	$1,600	$1,800
.405(4)	Contribution Limits—		
	Contributions made by political parties and caucus committees		
	State parties and caucus committees	.80 per voter	.90 per registered voter
	County and leg. district parties	.40 per voter	.45 per registered voter
	Limit for all county and leg. district parties to a candidate	.40 per voter	.45 per registered voter
.405(5)	Contribution Limits—		
	Contributions made by pol. parties and caucus committees to state official up for recall or committee supporting recall		
	State parties and caucuses	.80 per voter	.90 per registered voter
	County and leg. district parties	.40 per voter	.45 per registered voter
	Limit for all county and leg. district parties to state official up for recall or pol. comm. supporting recall	.40 per voter	.45 per registered voter
.405(7)	Limits on contributions to political parties and caucus committees		
	To caucus committee	$800	$900
	To political party	$4,000	$4,500
.410(1)	Candidates for judicial office	$1,600	$1,800
.475	Contribution must be made by written instrument	$80	$90

WSR 12-06-032
PROPOSED RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed March 2, 2012, 5:03 p.m.]

Supplemental Notice to WSR 11-24-060.

Preproposal statement of inquiry was filed as WSR 11-07-092.

Title of Rule and Other Identifying Information: Chapter 182-551 WAC, Subchapter I—Hospice services.

Hearing Location(s): Health Care Authority (HCA), Cherry Street Plaza Building, Apple Conference Room (106A), 626 8th Avenue, Olympia, WA 98504 (metered public parking is available street side around building. A map is available at http://maa.dshs.wa.gov/pdf/CherryStreetDirectionsNMap.pdf or directions can be obtained by calling (360) 725-1000), on April 10, 2012, at 10:00 a.m.

Date of Intended Adoption: Not sooner than April 11, 2012.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 45504, Olympia, WA 98504-5504, delivery 626 8th Avenue, Olympia, WA 98504, e-mail arc@hca.wa.gov, fax (360) 586-9727, by 5:00 p.m. on April 10, 2012.

Assistance for Persons with Disabilities: Contact Kelly Richters by April 2, 2012, TTY/TDD (800) 848-5429 or (360) 725-1307 or e-mail kelly.richters@hca.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: These proposed rules are necessary to:

(1) Establish that a family electing to receive hospice care for an individual under twenty-one years of age is no longer required to waive treatment for the terminal illness; and

(2) Require that a hospice physician or nurse practitioner must have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient prior to the one hundred eighty day recertification, and prior to each subsequent recertification and also attest that the visit took place.

Reasons Supporting Proposal: These required changes are in accordance with the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148). *The agency is holding a second public hearing to allow interested stakeholders the opportunity to review the revised proposed rules as a result of the comments received from the first public hearing.*

Statutory Authority for Adoption: RCW 41.05.021, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act.

Statute Being Implemented: RCW 41.05.021.

Rule is necessary because of federal law, Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and Section 1814 (a)(7) of the Social Security Act.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Wendy L. Boedigheimer, Health Care Authority, P.O. Box 45504, Olympia, WA, (360) 725-1306; Implementation and Enforcement: Ellen Silverman, Health Care Authority, P.O. Box 45506, Olympia, WA, (360) 725-1570.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The agency has analyzed the proposed rules and concludes that they do not impose more than minor costs for affected small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules [review] committee or applied voluntarily. However, the agency did draft a preliminary cost-benefit analysis and a copy of it may be obtained by contacting Ellen Silverman, RN, PhD, Nurse Clinical Consultant/Clinical Utilization Management Supervisor, Health Care Authority, Division of Healthcare Services, P.O. Box 45506, Olympia, WA 98504-5506, phone (360) 725-1570, fax (360) 586-9727, e-mail Ellen.silverman@hca.wa.gov.

March 1, 2012
Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1000 Hospice program—General. (1) The ((~~department's~~)) medicaid agency's hospice program is a twenty-four hour a day program that allows a terminally ill client to choose physical, pastoral/spiritual, and psychosocial comfort care ((~~rather than cure~~)) and a focus on quality of life. A hospice interdisciplinary team communicates with the client's nonhospice care providers to ensure the client's needs are met through the hospice plan of care. Hospitalization is used only for acute symptom management.

(2) A client, a physician, or an authorized representative under RCW 7.70.065 may initiate hospice care. The client's physician must certify the client as terminally ill and appropriate for hospice care.

(3) Hospice care is provided in a client's temporary or permanent place of residence.

(4) Hospice care ends when:

(a) The client or an authorized representative under RCW 7.70.065 revokes the hospice care;

(b) The hospice agency discharges the client;

(c) The client's physician determines hospice care is no longer appropriate; or

(d) The client dies.

(5) Hospice care includes the provision of emotional and spiritual comfort and bereavement support to the client's family member(s).

(6) ((~~Department-approved~~)) Medicaid agency-approved hospice agencies must meet the general requirements in chapter ((~~388-502~~)) 182-502 WAC, Administration of medical programs—Providers.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1010 Hospice program—Definitions. The following definitions and abbreviations and those found in WAC ((~~388-500-0005~~)) 182-500-0005, Medical definitions, apply to this subchapter.

"Authorized representative" ((~~means~~)) - An individual who has been authorized to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated. See RCW 7.70.065.

"Biologicals" ((~~means~~)) - Medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

"Brief period" ((~~means~~)) - Six days or less within a thirty consecutive-day period.

"Community services office (CSO)" ((~~means~~)) - An office of the department of social and health services (DSHS) that administers social and health services at the community level.

"Concurrent care" - Medically necessary services delivered at the same time as hospice services, providing a blend of curative and palliative services to clients twenty years of age and younger who are enrolled in hospice. See WAC 182-551-1860.

"Curative care" - Treatment aimed at achieving a disease-free state.

"Discharge" ((~~means an~~)) - A hospice agency ends hospice care for a client.

"Election period" ((~~means~~)) - The time, ninety or sixty days, that the client is certified as eligible for and chooses to receive hospice care.

"Family" ((~~means~~)) - An individual or individuals who are important to, and designated in writing by, the client and need not be relatives, or who are legally authorized to represent the client.

"Home and community services (HCS) office" ((~~means an~~)) - A department of social and health services (DSHS) aging and disability services administration (ADSA) office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to clients with functional disabilities.

((~~**"Home health aide"** means an individual registered or certified as a nursing assistant under chapter 18.88A RCW who, under the direction and supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist, assists in the delivery of nursing or therapy related~~

~~activities, or both, to patients of a hospice agency, or hospice care center.~~

~~**"Home health aide services"** means services provided by home health aides employed by an in-home services agency licensed to provide home health, hospice, or hospice care center services under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care may include ambulation and exercise, medication assistance level 1 and level 2, reporting changes in client's conditions and needs, completing appropriate records, and personal care or homemaker services, and other nonmedical tasks, as defined in this section.~~))

"Hospice agency" ((~~means~~)) - A person or entity administering or providing hospice services directly or through a contract arrangement to individuals in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and volunteer. (Note: For the purposes of this subchapter, requirements for hospice agencies also apply to hospice care centers.)

"Hospice aide" - An individual registered or certified as a nursing assistant under chapter 18.88A RCW who, under the direction and supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist, assists in the delivery of nursing or therapy related activities, or both, to patients of a hospice agency, or hospice care center.

"Hospice aide services" - Services provided by home health aides employed by an in-home services agency licensed to provide home health, hospice, or hospice care center services under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care may include ambulation and exercise, medication assistance level 1 and level 2, reporting changes in client's conditions and needs, completing appropriate records, and personal care or homemaker services, and other nonmedical tasks, as defined in this section.

"Hospice care center" ((~~means~~)) - A homelike noninstitutional facility where hospice services are provided, and that meets the requirements for operation under RCW 70.127.280 and applicable rules.

"Hospice services" ((~~means~~)) - Symptom and pain management provided to a terminally ill individual, and emotional, spiritual, and bereavement support for the individual and individual's family in a place of temporary or permanent residence.

"Interdisciplinary team" ((~~means~~)) - The group of individuals involved in client care providing hospice services or hospice care center services including, at a minimum, a physician, registered nurse, social worker, spiritual counselor, and volunteer.

"Palliative" ((~~means~~)) - Medical treatment designed to reduce pain or increase comfort, rather than cure.

"Plan of care" ((~~means~~)) - A written document based on assessment of client needs that identifies services to meet these needs.

"Related condition(s)" ((~~means~~)) - Any health condition((~~s~~))(s) that manifests secondary to or exacerbates symptoms associated with the progression of the condition and/or disease, the treatment being received, or the process of dying. (Examples of related conditions: Medication management of nausea and vomiting secondary to pain medication; skin breakdown prevention/treatment due to peripheral edema.)

"Residence" ((~~means~~)) - A client's home or place of living.

"Revoke" or **"revocation"** ((~~means~~)) - The choice to stop receiving hospice care.

"Terminally ill" ((~~means~~)) - The client has a life expectancy of six months or less, assuming the client's disease process runs its natural course.

"Twenty-four-hour day" ((~~means~~)) - A day beginning and ending at midnight.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1200 Client eligibility for hospice care. (1) A client who elects to receive hospice care must be eligible for one of the following medical assistance programs, subject to the restrictions and limitations in this chapter and other WAC:

(a) Categorically needy ((~~program (CNP)~~)) (CN);

(b) ((~~Limited casualty program - Medically needy program (LCP-MNP);~~

~~(c) Children's health (V);~~

~~(d) State children's health insurance program (SCHIP);~~

~~(e) CNP—Alien emergency medical;~~

~~(f) LCP-MNP—Alien emergency medical; or~~

~~(g) General assistance-expedited disability (GAX).~~)) Children's health care as described in WAC 388-505-0210;

(c) Medically needy (MN);

(d) Medical care services as described in WAC 182-508-0005 (within Washington state or designated border cities); or

(e) Alien emergency medical (AEM) as described in WAC 388-438-0110, when the medical services are necessary to treat a qualifying emergency medical condition.

(2) A hospice agency is responsible to verify a client's eligibility with the client or the client's department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO).

(3) A client enrolled in one of the ((~~department's~~)) medicaid agency's managed care ((~~plans~~)) organizations (MCO) must receive all hospice services, including facility room and board, directly through that ((~~plan~~)) MCO. The ((~~client's managed care plan~~)) MCO is responsible for arranging and providing all hospice services for ((~~a~~)) an MCO client ((~~enrolled in a managed care plan~~)).

(4) A client who is also eligible for medicare hospice under part A is not eligible for hospice care through the ((~~department's~~)) medicaid agency's hospice program. The ((~~department~~)) medicaid agency does pay hospice nursing facility room and board for these clients if the client is admitted to a nursing facility or hospice care center (HCC) and is not receiving general inpatient care or inpatient respite care. See also WAC ((~~388-551-1530~~)) 182-551-1530.

(5) A client who meets the requirements in this section is eligible to receive hospice care through the ((~~department's~~)) medicaid agency's hospice program when all of the following is met:

(a) The client's physician certifies the client has a life expectancy of six months or less.

(b) The client elects to receive hospice care and agrees to the conditions of the "election statement" as described in WAC ((~~388-551-1310~~)) 182-551-1310.

(c) The hospice agency serving the client:

(i) Notifies the ((~~department's~~)) medicaid agency's hospice program within five working days of the admission of all clients, including:

(A) Medicaid-only clients;

(B) Medicaid-medicare dual eligible clients;

(C) Medicaid clients with third party insurance; and

(D) Medicaid-medicare dual eligible clients with third party insurance.

(ii) Meets the hospice agency requirements in WAC ((~~388-551-1300~~)) 182-551-1300 and ((~~388-551-1305~~)) 182-551-1305.

(d) The hospice agency provides additional information for a diagnosis when the ((~~department~~)) medicaid agency requests and determines, on a case-by-case basis, the information that is needed for further review.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1210 Covered services, including core services and supplies reimbursed through the hospice daily rate. (1) The ((~~department~~)) medicaid agency reimburses a hospice agency for providing covered services, including core services and supplies described in this section, through the ((~~department's~~)) medicaid agency's hospice daily rate, subject to the conditions and limitations described in this section and other WAC. See WAC 182-551-1860 for pediatric concurrent care.

(2) To qualify for reimbursement, covered services, including core services and supplies in the hospice daily rate, must be:

(a) Related to the client's hospice diagnosis;

(b) Identified by the client's hospice interdisciplinary team;

(c) Written in the client's plan of care (POC); and

(d) Made available to the client by the hospice agency on a twenty-four hour basis.

(3) The hospice daily rate includes the following core services that must be either provided by hospice agency staff, or contracted through a hospice agency, if necessary, to supplement hospice staff in order to meet the needs of a client during a period of peak patient loads or under extraordinary circumstances:

(a) Physician services related to the administration of POC.

(b) Nursing care provided by:

(i) A registered nurse (RN); or

(ii) A licensed practical nurse (LPN) under the supervision of an RN.

(c) Medical social services provided by a social worker under the direction of a physician.

(d) Counseling services provided to a client and the client's family members or caregivers.

(4) Covered services and supplies may be provided by a service organization or an individual provider when contracted through a hospice agency. To be reimbursed the hospice daily rate, a hospice agency must:

(a) Assure all contracted staff meets the regulatory qualification requirements;

(b) Have a written agreement with the service organization or individual providing the services and supplies; and

(c) Maintain professional, financial, and administrative responsibility.

(5) The following covered services and supplies are included in the appropriate hospice daily rate as described in WAC ((~~388-551-1510(6)~~)) 182-551-1510(6), subject to the conditions and limitations described in this section and other WAC:

(a) Skilled nursing care;

(b) Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions;

(c) Communication with nonhospice providers about care not related to the client's terminal illness to ensure the client's plan of care needs are met and not compromised;

(d) ((~~Medical equipment and supplies that are medically necessary for the palliation and management of a client's terminal illness and related conditions;~~)) Durable medical equipment and related supplies, prosthetics, orthotics, medical supplies, related services, or related repairs and labor charges in accordance with WAC 182-543-9100 (6)(c). These services and equipment are paid by the hospice agency for the palliation and management of a client's terminal illness and related conditions and are included in the daily hospice rate;

(e) ((~~Home health~~)) Hospice aide, homemaker, and/or personal care services that are ordered by a client's physician and documented in the POC. (((~~Home health~~)) Hospice aide services are provided through the hospice agency to meet a client's extensive needs due to the client's terminal illness. These services must be provided by a qualified ((~~home health~~)) hospice aide and are an extension of skilled nursing or therapy services. See 42 CFR 484.36);

(f) Physical therapy, occupational therapy, and speech-language therapy to manage symptoms or enable a client to safely perform ADLs (activities of daily living) and basic functional skills;

(g) Medical transportation services, including ambulance (see WAC 182-546-5550 (1)(d));

(h) A brief period of inpatient care, for general or respite care provided in a medicare-certified hospice care center, hospital, or nursing facility; and

(i) Other services or supplies that are documented as necessary for the palliation and management of a client's terminal illness and related conditions;

(6) A hospice agency is responsible to determine if a nursing facility has requested authorization for medical supplies or medical equipment, including wheelchairs, for a client who becomes eligible for the hospice program. The ((~~department~~)) medicaid agency does not pay separately for medical equipment or supplies that were previously authorized by the ((~~department~~)) medicaid agency and delivered on

or after the date the ((~~department~~)) medicaid agency enrolls the client in the hospice program.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1300 Requirements for a ((~~department-approved~~)) medicaid-approved hospice agency. (1) To become a ((~~department-approved~~)) medicaid-approved hospice agency, the ((~~department~~)) medicaid agency requires a hospice agency to provide documentation that it is medicare, Title XVIII certified by the department of health (DOH) as a hospice agency.

(2) A ((~~department-approved~~)) medicaid-approved hospice agency must at all times meet the requirements in chapter ((~~388-551~~)) 182-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII medicare program.

(3) To ensure quality of care for medical assistance ((~~client's~~)) clients, the ((~~department's~~)) agency's clinical staff may conduct hospice agency site visits.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1305 Requirements for becoming a ((~~department-approved~~)) medicaid-approved hospice care center (HCC). (1) To apply to become a ((~~department-approved~~)) medicaid-approved hospice care center, the ((~~department~~)) medicaid agency requires a hospice agency to:

(a) Be enrolled with the ((~~department~~)) medicaid agency as ((~~a department~~)) an approved hospice agency (see WAC ((~~388-551-1300~~)) 182-551-1300);

(b) Submit a letter of request to:

Hospice Program Manager
((~~Division of Medical Management~~
~~Department of Social and Health Services~~))
P.O. Box 45506
Olympia, WA 98504-5506; and

(c) Include documentation that confirms the approved hospice agency is medicare certified by department of health (DOH) as a hospice care center and provides one or more of the following levels of hospice care (levels of care are described in WAC ((~~388-551-1500~~)) 182-551-1500):

(i) Routine home care;

(ii) Inpatient respite care; and

(iii) General inpatient care.

(2) A ((~~department-approved~~)) medicaid-approved hospice care center must at all times meet the requirements in chapter ((~~388-551~~)) 182-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII medicare program.

(3) A hospice agency qualifies as a ((~~department-approved~~)) medicaid-approved hospice care center when:

(a) All the requirements in this section are met; and

(b) The ((~~department~~)) medicaid agency provides the hospice agency with written notification.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1310 Hospice election periods, election statements, and the hospice certification process. (1) Hospice coverage is available for two ninety-day election periods followed by an unlimited number of sixty-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinitiate an election period for hospice care.

(2) The election statement must be filed in the client's hospice medical record within two calendar days following the day the hospice care begins and requires all of the following:

(a) Name and address of the hospice agency that will provide the care;

(b) Documentation that the client is fully informed and understands hospice care and waiver of other medicaid and/or medicare services;

(c) Effective date of the election; and

(d) Signature of the client or the client's authorized representative.

(3) The following describes the hospice certification process:

(a) When a client elects to receive hospice care, the ((~~department~~)) medicaid agency requires a hospice agency to:

(i) Obtain a signed written certification from a physician of the client's terminal illness; or

(ii) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by:

(A) The medical director of the hospice agency or a physician staff member of the interdisciplinary team; and

(B) The client's attending physician (if the client has one).

(iii) Place the signed written certification of the client's terminal illness in the client's medical file:

(A) Within sixty days following the day the hospice care begins; and

(B) Before billing the ((~~department~~)) medicaid agency for the hospice services.

(b) For subsequent election periods, the ((~~department~~)) medicaid agency requires ((~~the hospice agency to~~)):

(i) ((~~Obtain a signed written certification statement of the client's terminal illness; or~~

~~(ii) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by the medical director of the hospice agency or a physician staff member of the hospice agency; and~~

~~(iii) Place the written certification of the client's terminal illness in the client's medical file:~~

~~(A) Within two calendar days following the beginning of a subsequent election period; and~~

~~(B) Before billing the department for the hospice services.~~)) A hospice physician or hospice nurse practitioner to:

(A) Have a face-to-face encounter with every hospice client within thirty days prior to the one hundred eightieth-day recertification and prior to each subsequent recertification to determine continued eligibility of the client for hos-

pice care. The medicaid agency does not pay for face-to-face encounters to recertify a hospice client; and

(B) Attest that the face-to-face encounter took place.

(ii) The hospice agency to:

(A) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by the medical director of the hospice agency or a physician staff member of the hospice agency;

(B) Place the written certification of the client's terminal illness in the client's medical file before billing the medicaid agency for the hospice services; and

(C) Submit the written certification to the medicaid agency with the hospice claim related to the recertification.

(4) When a client's hospice coverage ends within an election period (e.g., the client revokes hospice care), the remainder of that election period is forfeited. The client may reinstate the hospice benefit at any time by providing an election statement and meeting the certification process requirements.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1330 Hospice—Client care and responsibilities of hospice agencies. (1) A hospice agency must facilitate a client's continuity of care with nonhospice providers to ensure that medically necessary care, both related and not related to the terminal illness, is met. This includes:

(a) Determining if the ((~~department~~)) medicaid agency has approved a request for prescribed medical equipment, such as a wheelchair. If the prescribed item is not delivered to the client before the client becomes covered by a hospice agency, the ((~~department~~)) medicaid agency will rescind the approval. See WAC ((~~388-543-1500~~)) 182-543-9100(7).

(b) Communicating with other ((~~department~~)) medicaid programs and documenting the services a client is receiving in order to prevent duplication of payment and to ensure continuity of care. Other ((~~department~~)) medicaid programs include, but are not limited to, programs administered by the department of social and health services aging and disability services administration (ADSA).

(c) Documenting each contact with nonhospice providers.

(2) When a client resides in a nursing facility, the hospice agency must:

(a) Coordinate the client's care with all providers, including pharmacies and medical vendors; and

(b) Provide the same level of hospice care the hospice agency provides to a client residing in their home.

(3) Once a client chooses hospice care, hospice agency staff must notify and inform the client of the following:

(a) By choosing hospice care from a hospice agency, the client gives up the right to:

(i) Covered medicaid hospice service and supplies received at the same time from another hospice agency; and

(ii) Any covered medicaid services and supplies received from any other provider that are necessary for the palliation and management of the terminal illness and related medical conditions.

(b) Services and supplies are not paid through the hospice daily rate if they are:

(i) Proven to be clinically unrelated to the palliation and management of the client's terminal illness and related medical conditions (see WAC ((~~388-551-1210(3)~~)) 182-551-1210(3));

(ii) Not covered by the hospice daily rate;

(iii) Provided under a Title XIX medicaid program when the services are similar or duplicate the hospice care services; or

(iv) Not necessary for the palliation and management of the client's terminal illness and related medical conditions.

(4) A hospice agency must have written agreements with all contracted providers.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1340 When a client leaves hospice without notice. When a client chooses to leave hospice care or refuses hospice care without giving the hospice agency a revocation statement, as required by WAC ((~~388-551-1360~~)) 182-551-1360, the hospice agency must do all of the following:

(1) Within five working days of becoming aware of the client's decision, inform and notify in writing the ((~~department's~~)) medicaid hospice program manager (see WAC ((~~388-551-1400~~)) 182-551-1400 for further requirements);

(2) Complete a medicaid hospice ((~~5-day~~)) notification form (((~~DSHS~~)) HCA 13-746) and forward a copy to the appropriate department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO) to notify that the client is discharging from the program;

(3) Notify the client, or the client's authorized representative, that the client's discharge has been reported to the ((~~department~~)) medicaid agency; and

(4) Document the effective date and details of the discharge in the client's hospice record.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1350 Discharges from hospice care. (1) A hospice agency may discharge a client from hospice care when the client:

(a) Is no longer certified for hospice care;

(b) Is no longer appropriate for hospice care; or

(c) The hospice agency's medical director determines the client is seeking treatment for the terminal illness outside the plan of care (POC).

(2) At the time of a client's discharge, a hospice agency must:

(a) Within five working days, complete a medicaid hospice ((~~5-day~~)) notification form (((~~DSHS~~)) HCA 13-746) and forward the form to the ((~~department's~~)) medicaid hospice program manager (see WAC ((~~388-551-1400~~)) 182-551-1400 for additional requirements), and a copy to the appropriate DSHS home and community services office (HCS) or community services office (CSO);

(b) Keep the discharge statement in the client's hospice record;

(c) Provide the client with a copy of the discharge statement; and

(d) Inform the client that the discharge statement must be:

(i) Presented with the client's current services card when obtaining medicaid covered ((~~healthcare~~)) health care services or supplies, or both; and

(ii) Used until the ((~~department~~)) medicaid agency removes the hospice restriction from the client's information available online at https://www.waproviderone.org.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1360 Ending hospice care (revocations). (1) A client or a client's authorized representative may choose to stop hospice care at any time by signing a revocation statement.

(2) The revocation statement documents the client's choice to stop medicaid hospice care. The revocation statement must include all of the following:

(a) Client's signature (or the client's authorized representative's signature if the client is unable to sign);

(b) Date the revocation was signed; and

(c) Actual date that the client chose to stop receiving hospice care.

(3) The hospice agency must keep any explanation supporting any difference in the signature and revocation dates in the client's hospice records.

(4) When a client revokes hospice care, the hospice agency must:

(a) Inform and notify in writing the medicaid agency's hospice program manager, within five working days of becoming aware of the client's decision((~~, inform and notify in writing the department's hospice program manager~~)) (see WAC ((~~388-551-1400~~)) 182-551-1400 for additional requirements);

(b) Notify the appropriate department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO) of the revocation by completing and forwarding a copy of the medicaid hospice ((~~5-day~~)) notification form (((~~DSHS~~)) HCA 13-746) to the appropriate DSHS home and community services (HCS) office or community services office (CSO);

(c) Keep the revocation statement in the client's hospice record;

(d) Provide the client with a copy of the revocation statement; and

(e) Inform the client that the revocation statement must be:

(i) Presented with the client's current ((~~medical identification (medical ID)~~)) services card when obtaining medicaid covered ((~~healthcare~~)) health care services or supplies, or both; and

(ii) Used until the ((~~department~~)) medicaid agency issues a new ((~~medical ID~~)) services card that identifies that the client is no longer a hospice client.

(5) After a client revokes hospice care, the remaining days within the current election period are forfeited. The client may immediately enter the next consecutive election period. The client does not have to wait for the forfeited days to pass before entering the next consecutive election period.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1370 When a hospice client dies. When a client dies, the hospice agency must:

(1) Within five working days, inform and notify in writing the ((~~department's~~)) medicaid agency's hospice program manager; and

(2) Notify the appropriate department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO) of the client's date of death by completing and forwarding a copy of the medicaid hospice ((~~5-day~~)) notification form (((~~DSHS~~)) HCA 13-746) to the appropriate DSHS HCS office or CSO.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1400 Notification requirements for hospice agencies. (1) To be reimbursed for providing hospice services, the hospice agency must complete a medicaid hospice ((~~5-day~~)) notification form (((~~DSHS~~)) HCA 13-746) and forward the form to the ((~~department's~~)) medicaid agency's hospice program manager within five working days from when a medical assistance client begins the first day of hospice care, or has a change in hospice status. The hospice agency must notify the ((~~department's~~)) medicaid hospice program of:

(a) The name and address of the hospice agency;

(b) The date of the client's first day of hospice care;

(c) A change in the client's primary physician;

(d) A client's revocation of the hospice benefit (home or institutional);

(e) The date a client leaves hospice without notice;

(f) A client's discharge from hospice care;

(g) A client who admits to a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care);

(h) A client who discharges from a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care.);

(i) A client who is eligible for or becomes eligible for medicare or third party liability (TPL) insurance;

(j) A client who dies; or

(k) A client who transfers to another hospice agency. Both the former agency and current agency must provide the ((~~department~~)) medicaid agency with:

(i) The client's name, the name of the former hospice agency servicing the client, and the effective date of the client's discharge; and

(ii) The name of the current hospice agency serving the client, the hospice agency's provider number, and the effective date of the client's admission.

(2) The ((~~department~~)) medicaid agency does not require a hospice agency to notify the hospice program manager

when a hospice client is admitted to a hospital for palliative care.

(3) When a hospice agency does not notify the ((~~department's~~)) medicaid agency's hospice program within five working days of the date of the client's first day of hospice care as required in subsection (1)(c) of this section, the ((~~department~~)) medicaid agency authorizes the hospice daily rate reimbursement effective the fifth working day prior to the date of notification.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1500 Hospice daily rate—Four levels of hospice care. All services, supplies and equipment related to the client's terminal illness and related conditions are included in the hospice daily rate. The ((~~department~~)) medicaid agency pays for only one of the following four levels of hospice care per day (see WAC 388-551-1510 for payment methods):

(1) **Routine home care.** Routine home care includes daily care administered to the client at the client's residence. The services are not restricted in length or frequency of visits, are dependent on the client's needs, and are provided to achieve palliation or management of acute symptoms.

(2) **Continuous home care.** Continuous home care includes acute skilled care provided to an unstable client during a brief period of medical crisis in order to maintain the client in the client's residence and is limited to:

(a) A minimum of eight hours of acute care provided during a twenty-four-hour day;

(b) Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care;

(c) Homemaker, ((~~home health~~)) hospice aide, and attendant services that may be provided as supplements to the nursing care; and

(d) In home care only (not care in a nursing facility or a hospice care center).

(3) **Inpatient respite care.** Inpatient respite care includes room and board services provided to a client in a ((~~department-approved~~)) medicaid-approved hospice care center, nursing facility, or hospital. Respite care is intended to provide relief to the client's primary caregiver and is limited to:

(a) No more than six consecutive days; and

(b) A client not currently residing in a hospice care center, nursing facility, or hospital.

(4) **General inpatient hospice care.** General inpatient hospice care includes services administered to a client for pain control or management of acute symptoms. In addition:

(a) The services must conform to the client's written plan of care (POC).

(b) This benefit is limited to brief periods of care in ((~~department-approved~~)) medicaid agency-approved:

(i) Hospitals;

(ii) Nursing facilities; or

(iii) Hospice care centers.

((~~(b)~~)) (c) There must be documentation in the client's medical record to support the need for general inpatient level of hospice care.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1510 Rates methodology and payment method for hospice agencies. This section describes rates methodology and payment methods for hospice care provided to hospice clients.

(1) The ((~~department~~)) medicaid agency uses the same rates methodology as medicare uses for the four levels of hospice care identified in WAC 388-551-1500.

(2) Each of the four levels of hospice care has the following three rate components:

(a) Wage component;

(b) Wage index; and

(c) Unweighted amount.

(3) To allow hospice payment rates to be adjusted for regional differences in wages, the department bases payment rates on the metropolitan statistical area (MSA) county location. MSAs are identified in the department's current published billing instructions.

(4) Payment rates for:

(a) Routine and continuous home care services are based on the county location of the client's residence.

(b) Inpatient respite and general inpatient care services are based on the MSA county location of the providing hospice agency.

(5) The ((~~department~~)) medicaid agency pays hospice agencies for services (not room and board) at a daily rate calculated as follows:

(a) Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence; or

(b) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(6) The ((~~department~~)) medicaid agency:

(a) Pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death;

(b) Does not pay room and board for the day of death; and

(c) Does not pay hospice agencies for the client's last day of hospice care when the last day is for the client's discharge, revocation, or transfer.

(7) Hospice agencies must bill the ((~~department~~)) medicaid agency for their services using hospice-specific revenue codes.

(8) For hospice clients in a nursing facility:

(a) The ((~~department~~)) medicaid agency pays nursing facility room and board payments at a daily rate directly to the hospice agency at ninety-five percent of the nursing facility's current medicaid daily rate in effect on the date the services were provided; and

(b) The hospice agency pays the nursing facility at a daily rate no greater than the nursing facility's current medicaid daily rate.

(9) The ((~~department~~)) medicaid agency:

(a) Pays a hospice care center a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

(b) Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

(i) A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or

(ii) The day of death.

(10) The daily rate for authorized out-of-state hospice services is the same as for in-state non-MSA hospice services.

(11) The client's notice of action (award) letter states the amount of participation the client is responsible to pay each month towards the total cost of hospice care. The hospice agency receives a copy of the award letter and:

(a) Is responsible to collect the correct amount of the client's participation if the client has any; and

(b) Must show the client's monthly participation on the hospice claim. (Hospice providers may refer to the ((~~department's~~)) medicaid agency's current published billing instructions for how to bill a hospice claim.) If a client has a participation amount that is not reflected on the claim and the ((~~department~~)) medicaid agency reimburses the amount to the hospice agency, the amount is subject to recoupment by the ((~~department~~)) medicaid agency.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1520 Payment method for nonhospice providers. (1) The ((~~department~~)) medicaid agency pays for hospitals that provide inpatient care to clients in the hospice program for medical conditions not related to their terminal illness according to chapter ((~~388-550~~)) 182-550 WAC, Hospital services.

(2) The ((~~department~~)) medicaid agency pays providers who are attending physicians and not employed by the hospice agency, the usual amount through the resource based relative value scale (RBRVS) fee schedule:

(a) For direct physician care services provided to a hospice client;

(b) When the provided services are not related to the terminal illness; and

(c) When the client's providers, including the hospice agency, coordinate the health care provided.

(3) The ((~~department's~~)) department of social and health services (DSHS) aging and disability services administration (ADSA) pays for services provided to a client eligible under the community options program entry system (COPES) directly to the COPES provider.

(a) The client's monthly participation amount, if there is one, for services provided under COPES is paid separately to the COPES provider; and

(b) Hospice agencies must bill the ((~~department's~~)) medicaid agency's hospice program directly for hospice services, not the COPES program.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1530 Payment method for medicaid-medicare dual eligible clients. (1) The ((~~department does not~~)) medicaid agency will not pay ((~~for any~~)) the portion of hospice care ((~~provided to~~)) for a client ((~~covered by medicare part A (hospital insurance)~~)) that is covered under medicare A. Nursing home room and board charges described in WAC 182-551-1510 that are not covered under medicare A may be covered by the medicaid agency.

(2) The ((~~department~~)) medicaid agency may pay for hospice care provided to a client:

(a) Covered by medicaid part B (medical insurance); and

(b) Not covered by medicare part A.

(3) For hospice care provided to a medicaid-medicare dual eligible client, hospice agencies are responsible to bill:

(a) Medicare before billing the ((~~department~~)) medicaid agency;

(b) The ((~~department~~)) medicaid agency for hospice nursing facility room and board;

(c) The ((~~department~~)) medicaid agency for hospice care center room and board; and

(d) Medicare for general inpatient care or inpatient respite care.

(4) All the limitations and requirements related to hospice care described in this subchapter apply to the payments described in this section.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1800 Pediatric palliative care (PPC) case management/coordination services—General. Through a hospice agency, the ((~~department's~~)) medicaid agency's pediatric palliative care (PPC) case management/coordination services provide the care coordination and skilled care services to clients who have life-limiting medical conditions. Family members and caregivers of clients eligible for pediatric palliative care services may also receive support through care coordination when the services are related to the client's medical needs.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1810 Pediatric palliative care (PPC) case management/coordination services—Client eligibility. To receive pediatric palliative care (PPC) case management/coordination services, a person must:

(1) Be twenty years of age or younger;

(2) Be a current recipient of the:

(a) Categorically needy program (CNP);

(b) Limited casualty program - Medically needy program (LCP-MNP);

(c) CNP((~~—~~)) - Alien emergency medical;

(d) LCP-MNP((~~—~~)) - Alien emergency medical;

(e) Children's health insurance program (SCHIP); and

(3) Have a life-limiting medical condition that requires case management and coordination of medical services due to at least three of the following circumstances:

(a) An immediate medical need during a time of crisis;

(b) Coordination with family member(s) and providers required in more than one setting (i.e., school, home, and multiple medical offices or clinics);

(c) A life-limiting medical condition that impacts cognitive, social, and physical development;

(d) A medical condition with which the family is unable to cope;

(e) A family member(s) and/or caregiver who needs additional knowledge or assistance with the client's medical needs; and

(f) Therapeutic goals focused on quality of life, comfort, and family stability.

(4) See WAC 182-551-1860 for concurrent palliative and curative care for hospice clients twenty years of age and younger.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1820 Pediatric palliative care (PPC) contact—Services included and limitations to coverage. (1) The ((~~department's~~)) medicaid agency's pediatric palliative care (PPC) case management/coordination services cover up to six pediatric palliative care contacts per client, per calendar month, subject to the limitations in this section and other applicable WAC.

(2) One pediatric palliative care contact consists of:

(a) One visit with a registered nurse, social worker, or therapist (for the purpose of this section, the ((~~department~~)) medicaid agency defines therapist as a licensed physical therapist, occupational therapist, or speech/language therapist) with the client in the client's residence to address:

(i) Pain and symptom management;

(ii) Psychosocial counseling; or

(iii) Education/training.

(b) Two hours or more per month of case management or coordination services to include any combination of the following:

(i) Psychosocial counseling services (includes grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death);

(ii) Establishing or implementing care conferences;

(iii) Arranging, planning, coordinating, and evaluating community resources to meet the client's needs;

(iv) Visits lasting twenty minutes or less (for example, visits to give injections, drop off supplies, or make appointments for other PPC-related services.); and

(v) Visits not provided in the client's home.

(3) The ((~~department~~)) medicaid agency does not pay for a pediatric palliative care contact described in subsection (2) of this section when a client is receiving services from any of the following:

(a) Home health program;

(b) Hospice program;

(c) Private duty nursing (private duty nursing can subcontract with PPC to provide services)/medical intensive care;

(d) Disease case management program; or

(e) Any other ((~~department~~)) medicaid program that provides similar services.

(4) The ((~~department~~)) medicaid agency does not pay for a pediatric palliative care contact that includes providing counseling services to a client's family member or the client's caregiver for grief or bereavement for dates of service after a client's death.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1830 How to become a ((~~department-approved~~)) medicaid-approved pediatric palliative care (PPC) case management/coordination services provider. This section applies to ((~~department-enrolled~~)) medicaid-approved providers who currently do not provide pediatric palliative care (PPC) services to medical assistance clients.

(1) To apply to become a ((~~department-approved~~)) medicaid-approved provider of PPC services, a provider must:

(a) Be a ((~~department-approved~~)) medicaid-approved hospice agency (see WAC ((~~388-551-1300~~)) 182-551-1300 and ((~~388-551-1305~~)) 182-551-1305); and

(b) Submit a letter to the ((~~department's~~)) medicaid agency's hospice/PPC program manager requesting to become a ((~~department-approved~~)) medicaid-approved provider of PPC and include a copy of the provider's policies and position descriptions with minimum qualifications specific to pediatric palliative care.

(2) A hospice agency qualifies to provide PPC services when:

(a) All the requirements in this section are met; and

(b) The ((~~department~~)) medicaid agency provides the hospice agency with written notification.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-551-1840 Pediatric palliative care (PPC) case management/coordination services—Provider requirements. (1) An eligible provider of pediatric palliative care (PPC) case management/coordination services must do all of the following:

(a) Meet the conditions in WAC ((~~388-551-1300~~)) 182-551-1300;

(b) Confirm that a client meets the eligibility criteria in WAC ((~~388-551-1810~~)) 182-551-1810 prior to providing the pediatric palliative care services;

(c) Place in the client's medical record a written order for PPC from the client's physician;

(d) Determine and document in the client's medical record the medical necessity for the initial and ongoing care coordination of pediatric palliative care services;

(e) Document in the client's medical record:

(i) A palliative plan of care (POC) (a written document based on assessment of a client's individual needs that identifies services to meet those needs).

(ii) The medical necessity for those services to be provided in the client's residence; and

(iii) Discharge planning.

(f) Provide medically necessary skilled interventions and psychosocial counseling services by qualified interdisciplinary hospice team members;

(g) Assign and make available a PPC case manager (nurse, social worker or therapist) to implement care coordination with community-based providers to assure clarity, effectiveness, and safety of the client's POC;

(h) Complete and fax the pediatric palliative care (PPC) referral and 5-day notification form (((~~DSHS~~)) HCA 13-752) to the ((~~department's~~)) medicaid agency's PPC program man-

ager within five working days from date of occurrence of the client's:

(i) Date of enrollment in PPC.

(ii) Discharge from the hospice agency or PPC program when the client:

(A) No longer meets PPC criteria;

(B) Is able to receive all care in the community;

(C) Does not require any services for sixty days; or

(D) Discharges from the PPC program and enrolls in the ((~~department's~~)) medicaid hospice program.

(iii) Transfer to another hospice agency for pediatric palliative care services.

(iv) Death.

(i) Maintain the client's file which includes the POC, visit notes, and all of the following:

(i) The client's start of care date and dates of service;

(ii) Discipline and services provided (in-home or place of service);

(iii) Case management activity and documentation of hours of work; and

(iv) Specific documentation of the client's response to the palliative care and the client's and/or client's family's response to the effectiveness of the palliative care (e.g., the client might have required acute care or hospital emergency room visits without the pediatric palliative care services).

(j) Provide when requested by the ((~~department's~~)) medicaid agency's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified in subsection (1)(i) of this section.

(2) If the ((~~department~~)) medicaid agency determines the POC, visit notes, and/or other required information do not meet the criteria for a client's PPC eligibility or does not justify the billed amount, any payment to the provider is subject to recoupment by the ((~~department~~)) medicaid agency.

NEW SECTION

WAC 182-551-1860 Concurrent care for hospice clients twenty years of age and younger. (1) In accordance with Section 2302 of the Patient Protection and Affordable Care Act of 2010 and Section 1814 (a)(7) of the Social Security Act, hospice palliative services are available to clients twenty years of age and younger without forgoing curative services which the client is entitled to under Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) for treatment of the terminal condition.

(2) Unless otherwise specified within this section, curative treatment including related services and medications requested for clients twenty years of age and younger are subject to the medicaid agency's specific program rules governing those services or medications.

(3) The following services aimed at achieving a disease-free state are included under the curative care benefit:

(a) Radiation;

(b) Chemotherapy;

(c) Diagnostics, including laboratory and imaging;

(d) Licensed health care professional services;

(e) Inpatient and outpatient hospital care;

(f) Surgery;

(g) Medication;

(h) Equipment and related supplies; and

(i) Ancillary services, such as medical transportation.

(4) The following are not included under the curative care benefit:

(a) Hospice covered services as described in WAC 182-551-1210;

(b) Services related to symptom management such as:

(I) Radiation;

(II) Chemotherapy;

(III) Surgery;

(IV) Medication; and

(V) Equipment and related supplies; and

(c) Ancillary services, such as medical transportation.

(5) Health care professionals must request prior authorization from the agency in accordance with WAC 182-501-0163 for enrollment in a concurrent care plan. Prior authorization requests are subject to medical necessity review under WAC 182-501-0165.

(6) If the curative treatment includes noncovered services in accordance with WAC 182-501-0070, the provider must request an exception to rule in accordance with WAC 182-501-0160.

(7) If the medicaid agency denies a request for a covered service, refer to WAC 182-502-0160, Billing a client, for when a client may be responsible to pay for a covered service.

WSR 12-06-038
PROPOSED RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed March 2, 2012, 1:54 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 10-06-116 and 10-20-160.

Title of Rule and Other Identifying Information: Repealing WAC 182-535-1065, 182-535-1247, 182-535-1255, 182-535-1257, 182-535-1259, 182-535-1261, 182-535-1263, 182-535-1266, 182-535-1267, 182-535-1269, 182-535-1271 and 182-535-1280; and amending WAC 182-535-1060, 182-535-1079, 182-535-1080, 182-535-1082, 182-535-1084, 182-535-1086, 182-535-1088, 182-535-1090, 182-535-1092, 182-535-1094, 182-535-1096, 182-535-1098, 182-535-1099, 182-535-1100, 182-535-1220, 182-535-1350, 182-535-1400, 182-535-1450, and 182-535-1500.

Hearing Location(s): Health Care Authority (HCA), Cherry Street Plaza Building, Conference Room, 626 8th Avenue, Olympia, WA 98504 (metered public parking is available street side around building. A map is available at http://maa.dshs.wa.gov/pdf/CherryStreetDirectionsNMap.pdf or directions can be obtained by calling (360) 725-1000), on April 10, 2012, at 10:00 a.m.

Date of Intended Adoption: Not sooner than April 11, 2012.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 45504, Olympia, WA 98504-5504, delivery 626 8th Avenue, Olympia, WA 98504, e-mail arc@hca.wa.gov, fax (360) 586-9727, by 5:00 p.m. on April 10, 2012.

Assistance for Persons with Disabilities: Contact Kelly Richters by April 2, 2012, TTY/TDD (800) 848-5429 or (360) 725-1307 or e-mail kelly.richters@hca.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Upon order of the governor, the agency reduced its budget expenditures for fiscal year 2011 by 6.3 percent. To achieve the expenditure reduction required under Executive Order 10-04, the agency took the following actions:

- **Effective January 1, 2011,** the agency eliminated dental-related services from program benefit packages for clients twenty-one years of age and older, except clients whose care is managed by the division of developmental disabilities (DDD), and implemented an emergency oral health benefit for all other adult clients.
- **Effective July 1, 2011,** in addition to clients whose care is managed by DDD, the agency reinstated comprehensive dental coverage for certain clients twenty-one years of age and older, as specified in the proposed rules.
- **Effective October 1, 2011,** the agency reduced eligibility for the comprehensive dental benefit for certain clients of DDD, as specified in the proposed rules.

Reasons Supporting Proposal: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required HCA and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3 percent. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments.

Statutory Authority for Adoption: RCW 41.05.021.

Statute Being Implemented: Section 209(1), chapter 37, Laws of 2010, (ESSB 6444); sections 201 and 209, chapter 564, Laws of 2009, (ESHB 1244).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Crabbe, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1346; Implementation and Enforcement: Dianne Baum, P.O. Box 45506, Olympia, WA 98504-5506, (360) 725-1590.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The agency has analyzed the proposed rule amendments and determined that there are no new costs associated with these changes and they do not impose disproportionate costs on small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules [review] committee or applied voluntarily.

March 2, 2012
Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1060 Clients who are eligible for dental-related services. (1) The ((~~following~~)) clients ((~~who receive services under the medical assistance programs listed~~)) described in this section are eligible ((~~for covered~~)) to receive the dental-related services((~~, subject to the restrictions and specific limitations~~)) described in this chapter ((~~and other applicable WAC:~~

~~(1) Children eligible for the~~)), subject to limitations, restrictions, and client-age requirements identified for a specific service.

(a) Clients who are eligible under one of the following medical assistance programs:

(((~~a~~))) (i) Categorically needy ((~~program~~)) (CN ((~~or CNP~~)));

(((~~b~~))) (ii) Children's ((~~health insurance program (CNP-CHIP)~~)) health care as described in WAC 388-505-0210; ((~~and~~

~~(c) Limited casualty program -~~))

(iii) Medically needy ((~~program~~)) (((~~LCP-MNP~~)) MN);

(iv) Medical care services (MCS) as described in WAC 182-508-0005;

(v) Alcohol and Drug Abuse Treatment and Support Act (ADATSA).

(((~~2) Adults eligible for the:~~

~~(a) Categorically needy program (CN or CNP); and~~

~~(b) Limited casualty program - medically needy program (LCP-MNP).~~

~~(3) Clients eligible for medical care services under the following state-funded only programs are eligible only for the limited dental-related services described in WAC 388-535-1065:~~

~~(a) General assistance - Unemployable (GA-U); and~~

~~(b) General assistance - Alcohol and Drug Abuse Treatment and Support Act (ADATSA) (GA-W).~~

~~(4)~~)) (b) Clients who are eligible under one of the medical assistance programs in subsection (a) of this section and are one of the following:

(i) Twenty years of age and younger;

(ii) Twenty years of age and younger enrolled in ((~~a~~)) an agency-contracted managed care ((~~plan are eligible for medical assistance administration (MAA)-covered dental services that are not covered by their plan,~~)) organization (MCO). MCO clients are eligible under fee-for-service for covered dental-related services not covered by their MCO plan, subject to the provisions of this chapter ((~~388-535 WAC~~)) and other applicable ((~~WAC~~)) agency rules;

(iii) For dates of service on and after July 1, 2011, clients who are verifiably pregnant;

(iv) For dates of service on and after July 1, 2011, clients residing in one of the following:

(A) Nursing home;

(B) Nursing facility wing of a state veteran's home;

(C) Privately operated intermediate care facility for the intellectually disabled (ICF/ID); or

(D) State-operated residential habilitation center (RHC).

(v) For dates of service on and after July 1, 2011, clients who are eligible under an Aging and Disability Services Administration (ADSA) 1915(c) waiver program;

(vi) For dates of service prior to October 1, 2011, clients of the division of developmental disabilities; or

(vii) For dates of service on and after October 1, 2011, clients of the division of developmental disabilities who also qualify under (b)(i), (iii), (iv), or (v) of this subsection.

(2) See WAC 388-438-0120 for rules for clients eligible under an alien emergency medical program.

(3) The dental services discussed in this chapter are excluded from the benefit package for clients not eligible for comprehensive dental services as described in subsection (1) of this section. Clients who do not have these dental services in their benefit package may be eligible only for the emergency oral health care benefit according to WAC 182-531-1025.

(4) Exception to rule procedures as described in WAC 182-501-0169 are not available for services that are excluded from a client's benefit package.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1079 Dental-related services ((for clients through age twenty))—General. (1) Clients described in WAC 182-535-1060 are eligible to receive the dental-related services described in this chapter, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service. The ((department)) agency pays for dental-related services and procedures provided to eligible clients ((through age twenty)) when the services and procedures:

(a) Are part of the client's dental benefit package;

(b) Are within the scope of an eligible client's medical care program;

(((b))) (c) Are medically necessary;

(((c))) (d) Meet the ((department's)) agency's prior authorization requirements, if any;

(((d))) (e) Are documented in the client's record in accordance with chapter ((388-502)) 182-502 WAC;

(((e))) (f) Are within accepted dental or medical practice standards;

(((f))) (g) Are consistent with a diagnosis of dental disease or condition;

(((g))) (h) Are reasonable in amount and duration of care, treatment, or service; and

(((h))) (i) Are listed as covered in the ((department's published)) agency's rules((,)) and published billing instructions and fee schedules.

(2) The agency requires site-of-service prior authorization, in addition to prior authorization of the procedure, if applicable, for nonemergency dental-related services performed in a hospital or an ambulatory surgery center when:

(a) A client is not a client of the division of developmental disabilities according to WAC 182-535-1099;

(b) A client is nine years of age or older;

(c) The service is not listed as exempt from the site-of-service authorization requirement in the agency's current published dental-related services fee schedule or billing instructions; and

(d) The service is not listed as exempt from the prior authorization requirement for deep sedation or general anesthesia (see WAC 182-535-1098 (1)(c)(v)).

(3) To be eligible for payment, dental-related services performed in a hospital or an ambulatory surgery center must be listed in the agency's current published outpatient fee schedule or ambulatory surgery center fee schedule. The claim must be billed with the correct procedure code for the site-of-service.

(4) Under the early periodic screening and diagnostic treatment (EPSDT) program, clients ((ages)) twenty years of age and younger may be eligible for dental-related services listed as noncovered.

(((3) Clients who are eligible for services through the division of developmental disabilities may receive dental-related services according to WAC 388-535-1099.

(4))) (5) The ((department)) agency evaluates a request for dental-related services that are:

(a) ((That are)) In excess of the dental program's limitations or restrictions, according to WAC ((388-501-0169)) 182-501-0169; and

(b) ((That are)) Listed as noncovered, according to WAC ((388-501-0160)) 182-501-0160.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1080 Covered dental-related services ((for clients through age twenty))—Diagnostic. ((The department covers medically necessary dental-related diagnostic services, subject to the coverage limitations listed, for clients through age twenty as follows:)) Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Clinical oral evaluations.** The ((department)) agency covers:

(a) Oral health evaluations and assessments.

(b) Periodic oral evaluations as defined in WAC ((388-535-1050)) 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(c) Limited oral evaluations as defined in WAC ((388-535-1050)) 182-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:

(i) Must be to evaluate the client for a:

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

(ii) When performed by a denturist, is limited to the initial examination appointment. The ((department)) agency does not cover any additional limited examination by a denturist for the same client until three months after a removable prosthesis has been seated.

(d) Comprehensive oral evaluations as defined in WAC ((388-535-1050)) 182-535-1050, once per client, per provider or clinic, as an initial examination. The ((department))

agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

(e) Limited visual oral assessments as defined in WAC ((~~388-535-1050~~)) 182-535-1050, up to two per client, per year, per provider only when the assessment is:

(i) Not performed in conjunction with other clinical oral evaluation services;

(ii) Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment and/or when triage services are provided in settings other than dental offices or clinics; and

(iii) Provided by a licensed dentist or licensed dental hygienist.

(2) **Radiographs (X rays).** The ((~~department~~)) agency:

(a) Covers radiographs that are of diagnostic quality, dated, and labeled with the client's name. The ((~~department~~)) agency requires:

(i) Original radiographs to be retained by the provider as part of the client's dental record((~~,~~)); and

(ii) Duplicate radiographs to be submitted:

(A) With requests for prior authorization ((~~requests, or~~)); and

(B) When the agency requests copies of dental records ((~~are requested~~)).

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers an intraoral complete series ((~~(includes four bitewings),~~)) once in a three-year period only if the ((~~department~~)) agency has not paid for a panoramic radiograph for the same client in the same three-year period. The intraoral complete series includes fourteen through twenty-two periapical and posterior bitewings. The agency limits reimbursement for all radiographs to a total payment of no more than payment for a complete series.

(d) Covers medically necessary periapical radiographs ((~~that are not included in a complete series~~)) for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting ((~~the~~)) medical necessity ((~~for these~~)) must be included in the client's record.

(e) Covers an occlusal intraoral radiograph once in a two-year period((~~. Documentation supporting the medical necessity for these must be included in the client's record~~)), for clients twenty years of age and younger.

(f) Covers ((~~a maximum of four bitewing radiographs once every twelve months for clients through age eleven~~)) oral facial photo images, only on a case-by-case basis when requested by the agency, for clients twenty years of age and younger.

(g) Covers a maximum of four bitewing radiographs (once per quadrant) once every twelve months ((~~for clients ages twelve through twenty~~)).

(h) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the ((~~department~~)) agency has not paid for an intraoral complete series for the same client in the same three-year period.

(i) May ((~~cover~~)) reimburse for panoramic radiographs for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized, except when required by an oral surgeon. For orthodontic services, see chapter 182-535A WAC.

(j) Covers cephalometric films((~~:~~

~~(i) For orthodontics, as described in chapter 388-535A WAC; or~~

~~(ii)~~)) once in a two-year period for clients twenty years of age and younger, only on a case-by-case basis and when prior authorized.

(k) Covers radiographs not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

(l) Covers oral and facial photographic images, only on a case-by-case basis and when requested by the ((~~department~~)) agency.

(3) **Tests and examinations.** The ((~~department~~)) agency covers the following for clients who are twenty years of age and younger:

(a) One pulp vitality test per visit (not per tooth):

(i) For diagnosis only during limited oral evaluations; and

(ii) When radiographs and/or documented symptoms justify the medical necessity for the pulp vitality test.

(b) Diagnostic casts other than those included in an orthodontic case study, on a case-by-case basis, and when requested by the ((~~department~~)) agency.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1082 Covered dental-related services ((~~for clients through age twenty~~))—Preventive services. Clients described in WAC 182-535-1060 are eligible for the ((~~department covers medically necessary~~)) dental-related preventive services((~~, subject to the coverage limitations~~)) listed in this section, ((~~for clients through age twenty as follows:~~)) subject to coverage limitations and client-age requirements identified for a specific service.

(1) **Dental prophylaxis.** The ((~~department~~)) agency covers prophylaxis as follows. Prophylaxis:

(a) ((~~Which~~)) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary((~~, transitional,~~)) or permanent dentition((~~, once every six months for clients through age twenty~~)).

(b) Is limited to once every:

(i) Six months for clients eighteen years of age and younger; and

(ii) Twelve months for clients nineteen years of age and older.

(c) Is reimbursed only when the service is performed:

(i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients ((~~ages~~)) from thirteen ((~~through twenty~~)) to eighteen years of age; and

(ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients nineteen years of age and older.

((~~(c) Only~~)) (d) Is not reimbursed separately when ((~~not~~)) performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.

(((d))) (e) Is covered for clients of the division of developmental disabilities according to (a), (c), and (d) of this subsection and WAC ((388-535-1099)) 182-535-1099.

(2) **Topical fluoride treatment.** The ((department)) agency covers:

(a) Fluoride ((varnish,)) rinse, foam or gel, including disposable trays, for clients ((ages)) six years of age and younger, up to three times within a twelve-month period.

(b) Fluoride ((varnish,)) rinse, foam or gel, including disposable trays, for clients ((ages)) from seven ((through)) to eighteen years of age, up to two times within a twelve-month period.

(c) Fluoride ((varnish,)) rinse, foam or gel, including disposable trays, up to three times within a twelve-month period during orthodontic treatment.

(d) Fluoride rinse, foam or gel, including disposable trays, for clients ((ages)) from nineteen ((through twenty)) to sixty-four years of age, once within a twelve-month period.

(e) Fluoride rinse, foam or gel, including disposable trays, for clients sixty-five years of age and older who reside in alternate living facilities, up to three times within a twelve-month period.

(f) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.

(((f))) (g) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC ((388-535-1099)) 182-535-1099.

(3) **Oral hygiene instruction.** The ((department)) agency covers:

(a) Oral hygiene instruction only for clients ((through age)) eight years of age and younger.

(b) Oral hygiene instruction, no more than once every six months, up to two times within a twelve-month period.

(c) Individualized oral hygiene instruction for home care to include tooth brushing technique, flossing, and use of oral hygiene aides.

(d) Oral hygiene instruction only when not performed on the same date of service as prophylaxis.

(e) Oral hygiene instruction only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

(4) **Sealants.** The ((department)) agency covers:

(a) Sealants for clients eighteen years of age and younger and clients of the division of developmental disabilities of any age.

(b) Sealants only when used on a mechanically and/or chemically prepared enamel surface.

(((b))) (c) Sealants once per tooth:

(i) In a three-year period for clients ((through age)) eighteen years of age and younger; and

(ii) In a two-year period for clients any age of the division of developmental disabilities according to WAC 182-535-1099.

(((c))) (d) Sealants only when used on the occlusal surfaces of:

(i) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one; and

(ii) Primary teeth A, B, I, J, K, L, S, and T.

(((d))) (e) Sealants on noncarious teeth or teeth with incipient caries.

(((e))) (f) Sealants only when placed on a tooth with no preexisting occlusal restoration, or any occlusal restoration placed on the same day.

(((f))) (g) Additional sealants not described in this subsection on a case-by-case basis and when prior authorized.

(5) **Space maintenance.** The ((department covers)) agency:

(a) Covers fixed unilateral or fixed bilateral space maintainers for clients ((through age eighteen)) twelve years of age and younger, subject to the following:

(i) Only one space maintainer is covered per quadrant.

(ii) Space maintainers are covered only for missing primary molars A, B, I, J, K, L, S, and T.

(iii) Replacement space maintainers are covered only on a case-by-case basis and when prior authorized.

(b) ((Only one space maintainer per quadrant.

(c) Space maintainers only for missing primary molars A, B, I, J, K, L, S, and T.

(d) Replacement space maintainers only on a case-by-case basis and when prior authorized.)) Covers removal of fixed space maintainers for clients eighteen years of age and younger.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1084 Covered dental-related services ((for clients through age twenty))—Restorative services. ((The department covers medically necessary dental-related restorative services, subject to the coverage limitations listed, for clients through age twenty as follows:)) Clients described in WAC 182-535-1060 are eligible for the dental-related restorative services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) ((**Restorative/operative procedures.** The department covers restorative/operative procedures performed in a hospital or an ambulatory surgical center for:

(a) Clients ages eight and younger;

(b) Clients ages nine through twenty only on a case-by-case basis and when prior authorized; and

(c) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(2))) **Amalgam and resin restorations for primary and permanent teeth.** The ((department)) agency considers:

(a) Tooth preparation, acid etching, all adhesives (including ((amalgam)) bonding agents), liners((,)) and bases, ((and)) polishing, and curing as part of the ((amalgam)) restoration.

(b) ((The)) Occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the amalgam restoration.

(c) ((Buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. The department covers one buccal and one lingual surface per tooth.

~~(d) Multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration.~~

~~(e) Amalgam~~)) Restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

((~~(3)~~ **~~Amalgam~~**)) (2) **Limitations for all restorations ((~~for primary posterior teeth only~~)).** The ((~~department covers amalgam restorations for a maximum of two surfaces for a primary first molar and maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this section for restorations for a primary posterior tooth requiring additional surfaces.) The department does not pay for additional amalgam restorations~~)) agency:

(a) Considers multiple restoration involving the proximal and occlusal surfaces of the same tooth as a multisurface restoration, and limits reimbursement to a single multisurface restoration.

(b) Considers multiple preventive restorative resins, flowable composite resins, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one-surface restoration.

(c) Considers multiple restorations of fissures and grooves of the occlusal surface of the same tooth as a one-surface restoration.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the dentoenamel junction (DEJ) to be sealants. (See WAC 182-535-1082(4) for sealant coverage.)

(e) Reimburses proximal restorations that do not involve the incisal angle on anterior teeth as a two-surface restoration.

(f) Covers only one buccal and one lingual surface per tooth. The agency reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.

(g) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial or distal) when performed on posterior teeth or the incisal surface of anterior teeth.

(h) Does not pay for replacement restorations within a two-year period unless the restoration has an additional adjoining carious surface. The agency pays for the replacement restoration as one multisurface restoration. The client's record must include X rays and documentation supporting the medical necessity for the replacement restoration.

((~~(4)~~ **~~Amalgam~~**)) (3) **Additional limitations on restorations ((~~for permanent posterior~~)) on primary teeth ((~~only~~)).** The ((~~department~~)) agency covers:

(a) ((~~Covers two occlusal amalgam restorations for teeth one, two, three fourteen, fifteen, and sixteen, if the restorations are anatomically separated by sound tooth structure.~~

~~(b) Covers amalgam restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.~~

~~(c) Covers amalgam restorations for a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen, once per client, per provider or clinic, in a two-year period (see (a) of this subsection).~~

~~(d) Does not pay for replacement of amalgam restoration on permanent posterior teeth within a two-year period unless the restoration has an additional adjoining carious surface. The department pays for the replacement restoration as one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration~~)) A maximum of two surfaces for a primary first molar. (See subsection (6) of this section for a primary first molar that requires a restoration with three or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(b) A maximum of three surfaces for a primary second molar. (See subsection (6) of this section for a primary posterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(c) A maximum of three surfaces for a primary anterior tooth. (See subsection (6) of this section for a primary anterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth after three surfaces.

(d) Glass ionomer restorations for primary teeth, only for clients five years of age and younger. The agency pays for these restorations as a one-surface, resin-based composite restoration.

((~~(5)~~ **~~Resin-based composite~~**)) (4) **Additional limitations on restorations ((~~for primary and~~)) on permanent teeth.** The ((~~department~~)) agency covers:

(a) ((~~Considers tooth preparation, acid etching, all adhesives (including resin bonding agents), liners and bases, polishing, and curing as part of the resin-based composite restoration.~~

~~(b) Considers the occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration.~~

~~(c) Considers buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. The department covers only one buccal and one lingual surface per tooth.~~

~~(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the DEJ to be sealants (see WAC 388-535-1082(4) for sealants coverage).~~

~~(e) Considers multiple preventive restorative resin, flowable composite resin, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration.~~

~~(f) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial and/or distal) when performed on posterior teeth or the incisal surface of anterior teeth.~~

~~(g) Considers resin-based composite restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.~~

~~(6)~~ **~~Resin-based composite restorations for primary teeth only.~~** ~~The department covers:~~

~~(a) Resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth (see subsection (9)(b) of this section for restorations for a primary anterior tooth requiring a four or more surface restoration). The department does not pay for additional composite or amalgam restorations on the same tooth after three surfaces.~~

(b) Resin-based composite restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this subsection for restorations for a primary posterior tooth requiring additional surfaces.) The department does not pay for additional composite restorations on the same tooth.

(c) Glass ionimer restorations only for primary teeth, and only for clients ages five and younger. The department pays for these restorations as a onesurface resin-based composite restoration.

(7) **Resin-based composite restorations for permanent teeth only.** The department covers:))

(a) Two occlusal ((resin-based composite)) restorations for the upper molars on teeth one, two, three, fourteen, fifteen, and sixteen if, the restorations are anatomically separated by sound tooth structure.

(b) ((Resin-based composite restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.

(c) Resin-based composite restorations for a maximum of six surfaces per tooth for permanent posterior teeth one, two, three, fourteen, fifteen, and sixteen, once per client, per provider or clinic, in a two-year period (see (a) of this subsection).

(d) Resin-based composite restorations for a maximum of six surfaces per tooth for a permanent anterior tooth, once per client, per provider or clinic, in a two-year period.

(e) Replacement of resin-based composite restoration on permanent teeth within a two-year period only if the restoration has an additional adjoining carious surface. The department pays the replacement restoration as a one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

(8))) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The agency allows a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen.

(c) A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

(5) **Crowns.** The ((department)) agency:

(a) Covers the following indirect crowns once every five years, per tooth, for permanent anterior teeth for clients ((ages)) from twelve ((through)) to twenty years of age when the crowns meet prior authorization criteria in WAC ((388-535-1220)) 182-535-1220 and the provider follows the prior authorization requirements in (((d))) (c) of this subsection:

(i) Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and

(ii) Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

(b) ((Covers full coverage metal crowns once every five years, per tooth, for permanent posterior teeth to include high noble, titanium, titanium alloys, noble, and predominantly base metal crowns for clients ages eighteen through twenty when they meet prior authorization criteria and the provider follows the prior authorization requirements in (d) and (e) of this subsection.

(c))) Considers the following to be included in the payment for a crown:

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The ((department)) agency covers a one-surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

(iii) Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

(vi) Crown seating (placement), including cementing and insulating bases;

(vii) Occlusal adjustment of crown or opposing tooth or teeth; and

(viii) Local anesthesia.

(((d))) (c) Requires the provider to submit the following with each prior authorization request:

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

(iii) Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;

(iv) Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and

(v) Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

(((e))) (d) Requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

(((9))) (6) **Other restorative services.** The ((department)) agency covers the following restorative services:

(a) All recementations of permanent indirect crowns only for clients from twelve to twenty years of age.

(b) Prefabricated stainless steel crowns with resin window, resin-based composite crowns, prefabricated esthetic coated stainless steel crowns, and fabricated resin crowns for primary anterior teeth once every three years ((without)) only for clients twenty years of age and younger as follows:

(i) For ages twelve and younger without prior authorization if the tooth requires a four or more surface restoration; and

(ii) For ages thirteen to twenty with prior authorization ((if the tooth requires a four or more surface restoration)).

(c) Prefabricated stainless steel crowns for primary posterior teeth once every three years without prior authorization if:

(i) Decay involves three or more surfaces for a primary first molar;

(ii) Decay involves four or more surfaces for a primary second molar; or

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns for permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every three years ((~~when~~)), for clients twenty years of age and younger, without prior ((~~authorized~~)) authorization.

(e) Prefabricated stainless steel crowns for clients of the division of developmental disabilities without prior authorization according to WAC ((~~388-535-1099~~)) 182-535-1099.

(f) Core buildup, including pins, only on permanent teeth, ((~~when~~)) only for clients twenty years of age and younger, and only allowed in conjunction with indirect crowns and prior authorized at the same time as the crown prior authorization.

(g) Cast post and core or prefabricated post and core, only on permanent teeth, only for clients twenty years of age and younger, and only when in conjunction with a crown and when prior authorized ((~~at the same time as the crown prior authorization~~)).

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1086 Covered dental-related services ((~~for clients through age twenty~~))—Endodontic services. ((~~The department covers medically necessary dental-related endodontic services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the dental-related endodontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Pulp capping.** The ((~~department~~)) agency considers pulp capping to be included in the payment for the restoration.

(2) **Pulpotomy.** The ((~~department~~)) agency covers:

(a) Therapeutic pulpotomy on primary ((~~posterior~~)) teeth only((~~; and~~)) for clients twenty years of age and younger.

(b) Pulpal debridement on permanent teeth only, excluding teeth one, sixteen, seventeen, and thirty-two. The ((~~department~~)) agency does not pay for pulpal debridement when performed with palliative treatment of dental pain or when performed on the same day as endodontic treatment.

(3) **Endodontic treatment.** The ((~~department~~)) agency:

(a) Covers endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment.

(b) Covers endodontic treatment for permanent anterior, bicuspid, and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two for clients twenty years of age and younger.

(c) Considers the following included in endodontic treatment:

(i) Pulpectomy when part of root canal therapy;

(ii) All procedures necessary to complete treatment; and

(iii) All intra-operative and final evaluation radiographs for the endodontic procedure.

(d) Pays separately for the following services that are related to the endodontic treatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(e) ((~~Requires~~)) Covers endodontic retreatment for clients twenty years of age and younger when prior ((~~authorization for endodontic retreatment and~~)) authorized.

(f) The agency considers endodontic retreatment to include:

(i) The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals;

(ii) Placement of new filling material; and

(iii) Retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two.

((~~(f)~~)) (g) Pays separately for the following services that are related to the endodontic retreatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

((~~(g)~~)) (h) Does not pay for endodontic retreatment when provided by the original treating provider or clinic unless prior authorized by the ((~~department~~)) agency.

((~~(h)~~)) (i) Covers apexification for apical closures for anterior permanent teeth only on a case-by-case basis and when prior authorized. Apexification is limited to the initial visit and three interim treatment visits and limited to clients twenty years of age and younger, per tooth.

((~~(i)~~)) (j) Covers apicoectomy and a retrograde fill for anterior teeth only for clients twenty years of age and younger.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1088 Covered dental-related services ((~~for clients through age twenty~~))—Periodontic services. ((~~The department covers medically necessary periodontic services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the dental-related periodontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specified service.

(1) **Surgical periodontal services.** The ((~~department~~)) agency covers the following surgical periodontal services, including all postoperative care:

(a) Gingivectomy/gingivoplasty only on a case-by-case basis and when prior authorized and only for clients twenty years of age and younger; and

(b) Gingivectomy/gingivoplasty for clients of the division of developmental disabilities according to WAC ((~~388-535-1099~~)) 182-535-1099.

(2) **Nonsurgical periodontal services.** The ((~~department~~)) agency:

(a) Covers periodontal scaling and root planing for clients from thirteen to eighteen years of age, once per quadrant, per client, in a two-year period, on a case-by-case basis, when

prior authorized ((~~for clients ages thirteen through eighteen~~)), and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least twelve calendar months from the completion of periodontal maintenance.

(b) Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients ((~~ages~~)) nineteen ((~~through twenty~~)) years of age and older. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

(d) Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

(e) Covers periodontal scaling and root planing for clients of the division of developmental disabilities according to WAC ((~~388-535-1099~~)) 182-535-1099.

(3) **Other periodontal services.** The ((~~department~~)) agency:

(a) Covers periodontal maintenance for clients from thirteen to eighteen years of age once per client in a twelve-month period on a case-by-case basis, when prior authorized, ((~~for clients ages thirteen through eighteen,~~)) and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting with location of the gingival margin and clinical attachment loss and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) ((~~Performed at least~~)) The client has had periodontal scaling and root planing but not within twelve months ((~~from~~)) of the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

(b) Covers periodontal maintenance once per client in a twelve month period for clients ((~~ages~~)) nineteen ((~~through twenty~~)) years of age and older. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Covers periodontal maintenance only if performed ((~~on a different date of service as~~)) at least twelve calendar months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(d) Covers periodontal maintenance for clients of the division of developmental disabilities according to WAC ((~~388-535-1099~~)) 182-535-1099.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1090 Covered dental-related services ((~~for clients through age twenty~~))—Prosthodontics (removable). ((~~The department covers medically necessary prosthodontics (removable) services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the prosthodontics (removable) and related services, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Prosthodontics.** The ((~~department~~)) agency:

(a) Requires prior authorization for all removable prosthodontic and prosthodontic-related procedures((~~, except as stated in (c)(ii)(B) of this subsection~~)). Prior authorization requests must meet the criteria in WAC ((~~388-535-1220~~)) 182-535-1220. In addition, the ((~~department~~)) agency requires the dental provider to submit:

(i) Appropriate and diagnostic radiographs of all remaining teeth.

(ii) A dental record which identifies:

(A) All missing teeth for both arches;

(B) Teeth that are to be extracted; and

(C) Dental and periodontal services completed on all remaining teeth.

((~~(iii) A prescription written by a dentist when a denturist's prior authorization request is for an immediate denture or a cast metal partial denture.~~))

(b) Covers complete dentures, as follows:

(i) A complete denture, including an ((~~immediate denture or~~)) overdenture, is covered when prior authorized.

(ii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat (placement) date of the complete denture, is considered part of the complete denture procedure and is not paid separately.

(iii) Replacement of an immediate denture with a complete denture is covered, if the complete denture is prior authorized at least six months after the seat date of the immediate denture.

(iv) ((~~Replacement of a complete denture or overdenture is covered only if prior authorized at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.~~)) Complete dentures are limited to:

(A) One initial maxillary complete denture and one initial mandibular complete denture per client, per the client's lifetime; and

(B) One replacement maxillary complete denture and one replacement mandibular complete denture per client, per client's lifetime.

(v) Replacement of a complete denture or overdenture is covered only if prior authorized, and only if the replacement occurs at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

(vi) The provider must obtain a signed denture agreement of acceptance (#13-809) from the client at the conclusion of the final denture try-in for an agency-authorized complete denture. If the client abandons the complete denture after signing the agreement of acceptance, the agency will

deny subsequent requests for the same type of dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency.

(c) Covers resin partial dentures, as follows:

(i) A partial denture((~~, including a resin or flexible base partial denture,~~)) is covered for anterior and posterior teeth when the partial denture meets the following ((~~department~~)) agency coverage criteria.

(A) The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) One or more anterior teeth are missing or four or more posterior teeth are missing (excluding teeth one, two, fifteen, sixteen, seventeen, eighteen, thirty-one, and thirty-two);

(D) There is a minimum of four stable teeth remaining per arch; and

(E) There is a three-year prognosis for retention of the remaining teeth.

(ii) Prior authorization ((~~of~~)) is required for partial dentures((~~:~~

~~(A) Is required for clients ages nine and younger; and~~

~~(B) Not required for clients ages ten through twenty. Documentation supporting the medical necessity for the service must be included in the client's file~~)).

(iii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the partial denture, is considered part of the partial denture procedure and is not paid separately.

(iv) Replacement of a ((~~resin or flexible base~~)) resin-based denture with any prosthetic is covered only if prior authorized at least three years after the seat date of the resin or flexible base partial denture being replaced. The replacement denture must be prior authorized and meet ((~~department~~)) agency coverage criteria in (c)(i) of this subsection.

(d) ((~~Covers cast-metal framework partial dentures, as follows:~~

~~(i) Cast-metal framework with resin-based partial dentures, including any conventional clasps, rests, and teeth, are covered for clients ages eighteen through twenty only once in a five-year period, on a case-by-case basis, when prior authorized and department coverage criteria listed in subsection (d)(v) of this subsection are met.~~

~~(ii) Cast-metal framework partial dentures for clients ages seventeen and younger are not covered.~~

~~(iii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the cast metal partial denture is considered part of the partial denture procedure and is not paid separately.~~

~~(iv) Replacement of a cast metal framework partial denture is covered on a case-by-case basis and only if placed at least five years after the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet department coverage criteria listed in (d)(v) of this subsection.~~

~~(v) Department authorization and payment for cast metal framework partial dentures is based on the following criteria:~~

~~(A) The remaining teeth in the arch must have a stable periodontal diagnosis and prognosis;~~

~~(B) The client has established caries control;~~

~~(C) All restorative and periodontal procedures must be completed before the request for prior authorization is submitted;~~

~~(D) There are fewer than eight posterior teeth in occlusion;~~

~~(E) There is a minimum of four stable teeth remaining per arch; and~~

~~(F) There is a five-year prognosis for the retention of the remaining teeth.~~

~~(vi) The department may consider resin partial dentures as an alternative if the department determines the criteria for cast metal framework partial dentures listed in (d)(v) of this subsection are not met.~~

~~(e)~~)) Does not cover replacement of a cast-metal framework partial denture, with any type of denture, within five years of the initial seat date of the partial denture.

(e) Requires a provider to bill for removable prosthetic procedures only after the seating of the prosthesis, not at the impression date. Refer to subsection (2)(e) and (f) of this section for what the ((~~department~~)) agency may pay if the removable prosthesis is not delivered and inserted.

(f) Requires a provider to submit the following with a prior authorization request for removable prosthetics for a client residing in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility:

(i) The client's medical diagnosis or prognosis;

(ii) The attending physician's request for prosthetic services;

(iii) The attending dentist's or denturist's statement documenting medical necessity;

(iv) A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed; and

(v) A completed copy of the denture/partial appliance request for skilled nursing facility client form (DSHS 13-788) available from the ((~~department's~~)) agency's published billing instructions.

(g) Limits removable partial dentures to resin-based partial dentures for all clients residing in one of the facilities listed in (f) of this subsection. ((~~The department may consider cast metal partial dentures if the criteria in subsection (1)(d) are met.~~))

(h) Requires a provider to deliver services and procedures that are of acceptable quality to the ((~~department~~)) agency. The ((~~department~~)) agency may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

(2) **Other services for removable prosthodontics.** The ((~~department~~)) agency covers:

(a) Adjustments to complete and partial dentures three months after the date of delivery.

(b) Repairs:

(i) To complete ((~~and partial~~)) dentures, once in a twelve-month period. The cost of repairs cannot exceed the cost of the replacement denture. The ((~~department~~)) agency covers additional repairs on a case-by-case basis and when prior authorized.

(ii) To partial dentures, once in a twelve-month period. The cost of the repairs cannot exceed the cost of the replace-

ment partial denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

(c) A laboratory reline or rebase to a complete or ((cast-metal)) partial denture, once in a three-year period when performed at least six months after the seating date. An additional reline or rebase may be covered for complete or ((cast-metal)) partial dentures on a case-by-case basis when prior authorized.

(d) Up to two tissue conditionings, only for clients twenty years of age and younger, and only when performed within three months after the seating date.

(e) Laboratory fees, subject to the following:

(i) The ((department)) agency does not pay separately for laboratory or professional fees for complete and partial dentures; and

(ii) The ((department)) agency may pay part of billed laboratory fees when the provider obtains prior authorization, and the client:

(A) Is not eligible at the time of delivery of the prosthesis;

(B) Moves from the state;

(C) Cannot be located;

(D) Does not participate in completing the complete, immediate, or partial dentures; or

(E) Dies.

(f) A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when billing for laboratory fees.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1092 Covered dental-related services ((for clients through age twenty))—Maxillofacial prosthetic services. ((The department covers medically necessary maxillofacial prosthetic services, subject to the coverage limitations listed, for clients through age twenty as follows:)) Clients described in WAC 182-535-1060 are eligible to receive the maxillofacial prosthetic services listed in this section, subject to the following:

(1) Maxillofacial prosthetics are covered only for clients twenty years of age and younger on a case-by-case basis and when prior authorized; and

(2) The ((department)) agency must preapprove a provider qualified to furnish maxillofacial prosthetics.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1094 Covered dental-related services ((for clients through age twenty))—Oral and maxillofacial surgery services. ((The department covers medically necessary oral and maxillofacial surgery services,)) Clients described in WAC 182-535-1060 are eligible to receive the oral and maxillofacial surgery services listed in this section, subject to the coverage limitations ((listed, for clients through age twenty as follows:)), restrictions, and client-age requirements identified for a specific service.

(1) **Oral and maxillofacial surgery services.** The ((department)) agency:

(a) Requires enrolled providers who do not meet the conditions in WAC ((388-535-1070)) 182-535-1070(3) to bill claims for services that are listed in this subsection using only the current dental terminology (CDT) codes.

(b) Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in WAC ((388-535-1070)) 182-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the ((department's)) agency's current published billing instructions as a CDT covered code (e.g., extractions).

(c) Covers nonemergency oral surgery performed in a hospital or ambulatory surgery center only for:

(i) Clients ((ages)) eight years of age and younger;

(ii) Clients ((ages)) from nine ((through)) to twenty years of age only on a case-by-case basis and when the site-of-service is prior authorized by the agency; and

(iii) Clients any age of the division of developmental disabilities ((according to WAC 388-535-1099)).

(d) For site-of-service and oral surgery CPT codes that require prior authorization, the agency requires the dental provider to submit:

(i) Documentation used to determine medical appropriateness;

(ii) Cephalometric films;

(iii) X rays;

(iv) Photographs; and

(v) Written narrative.

(e) Requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to the ((department)) agency. The documentation must include:

(i) Appropriate consent form signed by the client or the client's legal representative;

(ii) Appropriate radiographs;

(iii) Medical justification with diagnosis;

(iv) Client's blood pressure, when appropriate;

(v) A surgical narrative and complete description of each service performed beyond surgical extraction or beyond code definition;

(vi) A copy of the post-operative instructions; and

(vii) A copy of all pre- and post-operative prescriptions.

(((e))) (f) Covers routine and surgical extractions.

(((f))) (g) Requires prior authorization for unusual, complicated surgical extractions.

(h) Covers tooth reimplantation/stabilization of accidentally evulsed or displaced teeth for clients twenty years of age and younger.

(i) Covers surgical extraction of unerupted teeth for clients twenty years of age and younger.

(j) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The ((department)) agency includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

(((g))) (k) Covers ((biopsy, as follows)) the following without prior authorization:

(i) Biopsy of soft oral tissue ((or));

(ii) Brush biopsy ((do not require prior authorization; and

(ii))) for clients twenty years of age and younger.

(l) Requires providers to keep all biopsy reports or findings ((must be kept)) in the client's dental record.

(((h))) (m) Covers alveoloplasty for clients twenty years of age and younger only on a case-by-case basis and when prior authorized. The ((department)) agency covers alveoplasty only when not performed in conjunction with extractions.

(((i))) (n) Covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.

(((j))) (o) Covers only the following excisions of bone tissue in conjunction with placement of ((immediate,)) complete((,)) or partial dentures for clients twenty years of age and younger when prior authorized:

(i) Removal of lateral exostosis;

(ii) Removal of torus palatinus or torus mandibularis; and

(iii) Surgical reduction of soft tissue ((or)) osseous tuberosity.

(2) **Surgical incisions.** The ((department)) agency covers the following surgical incision-related services:

(a) Uncomplicated intraoral and extraoral soft tissue incision and drainage of abscess. The ((department)) agency does not cover this service when combined with an extraction or root canal treatment. Documentation supporting medical necessity must be in the client's record.

(b) Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue for clients twenty years of age and younger when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

(c) Frenuloplasty/frenulectomy for clients ((through age)) six years of age and younger without prior authorization. ((The department covers))

(d) Frenuloplasty/frenulectomy for clients ((ages)) from seven ((through)) to twelve years of age only on a case-by-case and when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

(3) **Occlusal orthotic devices.** (Refer to WAC ((388-535-1098 (5))) 182-535-1098 (4)(c) for occlusal guard coverage and limitations on coverage.) The ((department)) agency covers:

(a) Occlusal orthotic devices for clients ((ages)) from twelve ((through)) to twenty years of age only on a case-by-case basis and when prior authorized.

(b) An occlusal orthotic device only as a laboratory processed full arch appliance.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1096 Covered dental-related services ((for clients through age twenty))—Orthodontic services. (1) The ((department)) agency covers orthodontic services, subject to the coverage limitations listed, for clients ((through age)) twenty years of age and younger, according to chapter ((388-535A)) 182-535A WAC.

(2) The agency does not cover orthodontic services for clients twenty-one years of age and older.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1098 Covered dental-related services ((for clients through age twenty))—Adjunctive general services. ((The department covers medically necessary dental-related adjunctive general services, subject to the coverage limitations listed, for clients through age twenty as follows:)) Clients described in WAC 182-535-1060 are eligible to receive the adjunctive general services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Adjunctive general services.** The ((department)) agency:

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC ((388-535-1086)) 182-535-1086 (2)(b)), for treatment of dental pain, for clients twenty years of age and younger, limited to once per day, per client, as follows:

(i) The treatment must occur during limited evaluation appointments;

(ii) A comprehensive description of the diagnosis and services provided must be documented in the client's record; and

(iii) Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

(b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.

(c) Covers office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows:

(i) The provider's current anesthesia permit must be on file with the ((department)) agency.

(ii) For clients ((of the division of developmental disabilities, the services must be performed according to WAC 388-535-1099.

(iii) For clients ages)) eight years of age and younger, and for clients any age of the division of developmental disabilities, documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(((iv))) (iii) For clients ((ages)) from nine ((through)) to twenty years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services listed in WAC ((388-535-1094)) 182-535-1094, deep sedation or general anesthesia services do not require prior authorization.

(((v))) (iv) Prior authorization is not required for oral or parenteral conscious sedation for any dental service for clients twenty years of age and younger, and for clients any age of the division of developmental disabilities. Documentation supporting the medical necessity of the service must be in the client's record.

(((vi))) (v) For clients ((ages)) from nine ((through eighteen)) to twenty years of age who have a diagnosis of oral facial cleft, the ((department)) agency does not require prior authorization for deep sedation or general anesthesia services when the dental procedure is directly related to the oral facial cleft treatment.

(((vii) For clients through age twenty, the)) (vi) A provider must bill anesthesia services using the CDT codes listed

in the ((department's)) agency's current published billing instructions.

(d) Covers ((inhalation)) administration of nitrous oxide ((for clients through age twenty)), once per day.

(e) Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

(f) Pays for dental anesthesia services according to WAC ((388-535-1350)) 182-535-1350.

(g) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the ((department)) agency for the services to be covered.

(2) ((**Nonemergency dental services.** The department covers nonemergency dental services performed in a hospital or ambulatory surgical center only for:

(a) Clients ages eight and younger.

(b) Clients ages nine through twenty only on a case-by-case basis and when prior authorized.

(c) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(3))) **Professional visits.** The ((department)) agency covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The ((department)) agency limits payment to two facilities per day, per provider.

(b) One hospital call (visit), including emergency care, per day, per provider, per client, and not in combination with a surgical code unless the decision for surgery is a result of the visit.

(c) Emergency office visits after regularly scheduled hours. The ((department)) agency limits payment to one emergency visit per day, per client, per provider.

(((4))) (3) **Drugs and/or medicaments (pharmaceuticals).** The ((department)) agency covers drugs and/or medicaments only when used with parenteral conscious sedation, deep sedation, or general anesthesia for clients twenty years of age and younger. The ((department's)) agency's dental program does not pay for oral sedation medications.

(((5))) (4) **Miscellaneous services.** The ((department)) agency covers:

(a) Behavior management when the assistance of one additional dental staff other than the dentist is required((,)) for the following clients and documentation supporting the need for the behavior management must be in the client's record:

(i) Clients ((ages)) eight years of age and younger;

(ii) Clients ((ages)) from nine ((through)) to twenty years of age, only on a case-by-case basis and when prior authorized;

(iii) Clients any age of the division of developmental disabilities ((according to WAC 388-535-1099)); and

(iv) Clients who reside in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility.

(b) Treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity of the service must be in the client's record.

(c) Occlusal guards when medically necessary and prior authorized. (Refer to WAC ((388-535-1094)) 182-535-1094(3) for occlusal orthotic device coverage and coverage limitations.) The ((department)) agency covers:

(i) An occlusal guard only for clients ((ages)) from twelve ((through)) to twenty years of age when the client has permanent dentition; and

(ii) An occlusal guard only as a laboratory processed full arch appliance.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1099 Covered dental-related services for clients of the division of developmental disabilities. Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the ((department)) agency pays for the dental-related services listed under the categories of services ((listed)) in this section ((for)) that are provided to clients of the division of developmental disabilities((, subject to the coverage limitations listed)). This chapter ((388-535 WAC)) also applies to clients of the division of developmental disabilities, regardless of age, unless otherwise stated in this section.

(1) **Preventive services.**

(a) Dental prophylaxis. The ((department)) agency covers dental prophylaxis or periodontal maintenance up to three times in a twelve-month period (see subsection (3) of this section for limitations on periodontal scaling and root planing).

(b) Topical fluoride treatment. The ((department)) agency covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period.

(c) Sealants. The ((department)) agency covers sealants:

(i) Only when used on the occlusal surfaces of:

(A) Primary teeth A, B, I, J, K, L, S, and T; or

(B) Permanent teeth two, three, four, five, twelve, thirteen, fourteen, fifteen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, and thirty-one.

(ii) Once per tooth in a two-year period.

(2) **Crowns.** The ((department)) agency covers stainless steel crowns every two years for the same tooth and only for primary molars and permanent premolars and molars, as follows:

(a) For clients ages twenty and younger, the ((department)) agency does not require prior authorization for stainless steel crowns. Documentation supporting the medical necessity of the service must be in the client's record.

(b) For clients ((ages)) twenty-one years of age and older, the ((department)) agency requires prior authorization for stainless steel crowns when the tooth has had a pulpotomy and only for:

(i) Primary first molars when the decay involves three or more surfaces; and

(ii) Second molars when the decay involves four or more surfaces.

(3) **Periodontic services.**

(a) **Surgical periodontal services.** The ((~~department~~)) agency covers:

(i) Gingivectomy/gingivoplasty once every three years. Documentation supporting the medical necessity of the service must be in the client's record (e.g., drug induced gingival hyperplasia).

(ii) Gingivectomy/gingivoplasty with periodontal scaling and root planing or periodontal maintenance when the services are performed:

(A) In a hospital or ambulatory surgical center; or

(B) For clients under conscious sedation, deep sedation, or general anesthesia.

(b) **Nonsurgical periodontal services.** The ((~~department~~)) agency covers:

(i) Periodontal scaling and root planing, ((~~up to two~~)) one time((~~s~~)) per quadrant in a twelve-month period.

(ii) Periodontal ((~~scaling~~)) maintenance (four quadrants) substitutes for an eligible periodontal ((~~maintenance or oral prophylaxis~~)) scaling or root planing, twice in a twelve-month period.

(iii) Periodontal maintenance allowed six months after scaling or root planing.

(4) **Adjunctive general services.** ((~~(a)~~ ~~**Adjunctive general services.**~~)) The ((~~department~~)) agency covers:

((~~(i)~~)) (a) Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.

((~~(ii)~~)) (b) Sedations services according to WAC ((~~388-535-1098~~)) 182-535-1098 (1)(c) and (e).

((~~(b)~~)) (5) **Nonemergency dental services.** The ((~~department~~)) agency covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC ((~~388-535-1082, 388-535-1084, 388-535-1086, 388-535-1088, and 388-535-1094~~)) 182-535-1082, 182-535-1084, 182-535-1086, 182-535-1088, and 182-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

((~~(5)~~)) (6) **Miscellaneous services—Behavior management.** The ((~~department~~)) agency covers behavior management provided in dental offices or dental clinics ((~~for clients of any age~~)). Documentation supporting the medical necessity of the service must be included in the client's record.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1100 Dental-related services not covered ((~~for clients through age twenty~~)). (1) The ((~~department~~)) agency does not cover the following ((~~for clients through age twenty~~)):

(a) The dental-related services described in subsection (2) of this section unless the services are covered under the early periodic screening, diagnosis and treatment (EPSDT) program. See WAC ((~~388-534-0100~~)) 182-534-0100 for information about the EPSDT program.

(b) Any service specifically excluded by statute.

(c) More costly services when less costly, equally effective services as determined by the ((~~department~~)) agency are available.

(d) Services, procedures, treatment, devices, drugs, or application of associated services:

(i) ((~~Which~~)) That the ((~~department~~)) agency or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided.

(ii) That are not listed as covered in one or both of the following:

(A) Washington Administrative Code (WAC).

(B) The ((~~department's~~)) agency's current published documents.

(2) The ((~~department~~)) agency does not cover dental-related services listed under the following categories of service ((~~for clients through age twenty~~)) (see subsection (1)(a) of this section for services provided under the EPSDT program):

(a) **Diagnostic services.** The ((~~department~~)) agency does not cover:

(i) Detailed and extensive oral evaluations or reevaluations.

(ii) Extraoral radiographs.

((~~(ii) Comprehensive periodontal evaluations.~~)) (iii) Posterior-anterior or lateral skull and facial bone survey films.

(iv) Any temporomandibular joint films.

(v) Tomographic surveys.

(vi) Cephalometric films, for clients twenty-one years of age and older.

(vii) Oral/facial photographic images, for clients twenty-one years of age and older.

(viii) Comprehensive periodontal evaluations.

(ix) Occlusal intraoral radiographs, for clients twenty-one years of age and older.

(x) Viral cultures, genetic testing, caries susceptibility tests, or adjunctive prediagnostic tests.

(xi) Pulp vitality tests, for clients twenty-one years of age and older.

(xii) Diagnostic casts, for clients twenty-one years of age and older.

(b) **Preventive services.** The ((~~department~~)) agency does not cover:

(i) Nutritional counseling for control of dental disease.

(ii) Tobacco counseling for the control and prevention of oral disease.

(iii) Removable space maintainers of any type.

(iv) Oral hygiene instructions for clients nine years of age and older. This is included as part of the global fee for oral prophylaxis.

(v) Sealants placed on a tooth with the same-day occlusal restoration, preexisting occlusal restoration, or a tooth with occlusal decay.

((~~(v)~~)) (vi) Sealants, for clients twenty years of age and older. For clients of the division of developmental disabilities, see WAC 182-535-1099.

(vii) Space maintainers, for clients ((~~ages~~)) nineteen ((~~through twenty~~)) years of age and older.

(viii) Recementation of space maintainers, for clients twenty-one years of age and older.

(ix) Custom fluoride trays of any type.

(x) Bleach trays.

(c) **Restorative services.** The ((~~department~~)) agency does not cover:

(i) Restorations for wear on any surface of any tooth without evidence of decay through the dentoenamel junction (DEJ) or on the root surface.

(ii) Gold foil restorations.

((~~(ii)~~)) (iii) Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations.

((~~(iii)~~)) (iv) Prefabricated resin crowns, for clients twenty-one years of age and older.

(v) Preventive restorations.

(vi) Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining).

((~~(iv)~~)) (vii) Permanent indirect crowns for ((~~third molars one, sixteen, seventeen, and thirty-two~~)) molar teeth.

((~~(v)~~)) (viii) Permanent indirect crowns on permanent anterior teeth for clients fourteen years of age and younger.

(ix) Temporary or provisional crowns (including ion crowns).

((~~(vi)~~)) (x) Labial veneer resin or porcelain laminate restorations.

((~~(vii)~~)) (xi) Recementation of any crown, inlay/onlay, or any other type of indirect restoration, for clients twenty-one years of age and older.

(xii) Sedative fillings.

(xiii) Any type of core buildup, cast post and core, or prefabricated post and core, for clients twenty-one years of age and older.

(xiv) Any type of coping.

((~~(viii)~~)) (xv) Crown repairs.

((~~(ix)~~)) (xvi) Polishing or recontouring restorations or overhang removal for any type of restoration.

(xvii) Amalgam restorations of primary posterior teeth for clients sixteen years of age and older.

(xviii) Crowns on teeth one, sixteen, seventeen, and thirty-two.

(xix) Any services other than extraction on supernumerary teeth.

(d) **Endodontic services.** The ((~~department~~)) agency does not cover:

(i) The following endodontic services for clients twenty-one years of age and older:

(A) Endodontic therapy on permanent bicuspids;

(B) Any apexification/recalcification procedures; or

(C) Any apicoectomy/periradicular service.

(ii) Apexification/recalcification for root resorption of permanent anterior teeth.

(iii) The following endodontic services:

(A) Indirect or direct pulp caps.

(B) Any endodontic therapy on primary teeth, except as described in WAC ((~~388-535-1086~~)) 182-535-1086 (3)(a).

((~~(ii) Apexification/recalcification for root resorption of permanent anterior teeth.~~

~~(iii)~~)) (C) Endodontic therapy on molar teeth.

(D) Any apexification/recalcification procedures for bicuspid or molar teeth.

((~~(iv)~~)) (E) Any apicoectomy/periradicular services for bicuspid teeth or molar teeth.

((~~(v)~~)) (F) Any surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

(e) **Periodontic services.** The ((~~department~~)) agency does not cover:

(i) Surgical periodontal services including, but not limited to:

(A) Gingival flap procedures.

(B) Clinical crown lengthening.

(C) Osseous surgery.

(D) Bone or soft tissue grafts.

(E) Biological material to aid in soft and osseous tissue regeneration.

(F) Guided tissue regeneration.

(G) Pedicle, free soft tissue, apical positioning, subepithelial connective tissue, soft tissue allograft, combined connective tissue and double pedicle, or any other soft tissue or osseous grafts.

(H) Distal or proximal wedge procedures.

(ii) Nonsurgical periodontal services including, but not limited to:

(A) Intracoronal or extracoronal provisional splinting.

(B) Full mouth or quadrant debridement.

(C) Localized delivery of chemotherapeutic agents.

(D) Any other type of nonsurgical periodontal service.

(f) **Removable prosthodontics.** The ((~~department~~)) agency does not cover:

(i) Removable unilateral partial dentures.

(ii) Adjustments to any removable prosthesis.

(iii) Any interim complete or partial dentures.

((~~(iii)~~)) (iv) Flexible base partial dentures.

(v) Any type of permanent soft reline (e.g., molloplast).

(vi) Precision attachments.

((~~(iv)~~)) (vii) Replacement of replaceable parts for semi-precision or precision attachments.

(viii) Replacement of second or third molars for any removable prosthesis.

(ix) Immediate dentures.

(x) Cast-metal framework partial dentures.

(g) **Implant services.** The ((~~department~~)) agency does not cover:

(i) Any type of implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implants, eposteal implants, and transosteal implants), abutments or implant supported crowns, abutment supported retainers, and implant supported retainers.

(ii) Any maintenance or repairs to procedures listed in (g)(i) of this subsection.

(iii) The removal of any implant as described in (g)(i) of this subsection.

(h) **Fixed prosthodontics.** The ((~~department~~)) agency does not cover any type of:

(i) ((~~Any type of~~)) Fixed partial denture pontic ((~~or~~)).

(ii) Fixed partial denture retainer.

((~~(ii) Any type of~~)) (iii) Precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.

(((i))) (iv) Occlusal orthotic splint or device, bruxing or grinding splint or device, temporomandibular joint splint or device, or sleep apnea splint or device.

(v) Orthodontic service or appliance, for clients twenty-one years of age and older.

(i) **Oral maxillofacial prosthetic services.** The agency does not cover any type of oral or facial prosthesis other than those listed in WAC 182-535-1092.

(j) **Oral and maxillofacial surgery.** The ((department)) agency does not cover:

(i) Any oral surgery service not listed in WAC ((388-535-1094)) 182-535-1094.

(ii) Any oral surgery service that is not listed in the ((department's)) agency's list of covered current procedural terminology (CPT) codes published in the ((department's)) agency's current rules or billing instructions.

(((j))) (iii) Vestibuloplasty.

(iv) Frenuloplasty/frenulectomy, for clients twenty-one years of age and older.

(k) **Adjunctive general services.** The ((department)) agency does not cover:

(i) Anesthesia, including, but not limited to:

(A) Local anesthesia as a separate procedure.

(B) Regional block anesthesia as a separate procedure.

(C) Trigeminal division block anesthesia as a separate procedure.

(D) Medication for oral sedation, or therapeutic intramuscular (IM) drug injections, including antibiotic and injection of sedative.

(E) Application of any type of desensitizing medicament or resin.

(ii) General anesthesia for clients twenty-one years of age and older.

(iii) Oral or parenteral conscious sedation for clients twenty-one years of age and older.

(iv) Analgesia or anxiolysis as a separate procedure except for administration of nitrous oxide for clients twenty-one years of age and older.

(v) Other general services including, but not limited to:

(A) Fabrication of an athletic mouthguard.

(B) Occlusal guards for clients twenty-one years of age and older.

(C) Nightguards.

(D) Occlusion analysis.

(((C))) (E) Occlusal adjustment, tooth or restoration adjustment or smoothing, or odontoplasties.

(((D))) (F) Enamel microabrasion.

(((E))) (G) Dental supplies such as toothbrushes, toothpaste, floss, and other take home items.

(((F))) (H) Dentist's or dental hygienist's time writing or calling in prescriptions.

(((G))) (I) Dentist's or dental hygienist's time consulting with clients on the phone.

(((H))) (J) Educational supplies.

(((I))) (K) Nonmedical equipment or supplies.

(((J))) (L) Personal comfort items or services.

(((K))) (M) Provider mileage or travel costs.

(((L))) (N) Fees for no-show, ((cancelled)) canceled, or late arrival appointments.

(((M))) (O) Service charges of any type, including fees to create or copy charts.

(((N))) (P) Office supplies used in conjunction with an office visit.

(((O))) (Q) Teeth whitening services or bleaching, or materials used in whitening or bleaching.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1220 Obtaining prior authorization for dental-related services ((for clients through age twenty)). (1) The ((department)) agency uses the determination process for payment described in WAC ((388-501-0165)) 182-501-0165 for covered dental-related services ((for clients through age twenty)) that require prior authorization.

(2) The ((department)) agency requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on ((an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611)) DSHS form 13-835, available on the agency's web site.

(3) The ((department)) agency may request additional information as follows:

(a) Additional radiographs (X rays) (refer to WAC ((388-535-1080)) 182-535-1080(2))((.));

(b) Study models;

(c) Photographs; and

(d) Any other information as determined by the ((department)) agency.

(4) The ((department)) agency may require second opinions and/or consultations before authorizing any procedure.

(5) When the ((department)) agency authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The authorization is valid for six months and only if the client is eligible for covered services on the date of service.

(6) The ((department)) agency denies a request for a dental-related service when the requested service:

(a) Is covered by another ((department)) agency program;

(b) Is covered by an agency or other entity outside the ((department)) agency; or

(c) Fails to meet the program criteria, limitations, or restrictions in this chapter ((388-535 WAC)).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1350 Payment methodology for dental-related services. The ((medical assistance administration (MAA))) agency uses the description of dental services described in the American Dental Association's Current Dental Terminology (CDT), and the American Medical Association's Physician's Current Procedural Terminology (CPT).

(1) For covered dental-related services provided to eligible clients, ((MAA)) the agency pays dentists and other eligi-

ble providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC ((~~388-535-1100~~)) 182-535-1100 and ((~~388-535-1400~~)) 182-535-1400.

(2) ((~~MAA~~)) The agency sets maximum allowable fees for dental services ((~~provided to children~~)) as follows:

(a) ((~~MAA's~~)) The agency's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) ((~~MAA~~)) The agency consults with representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) ((~~MAA~~)) The agency consults with dental experts and public health professionals to identify and prioritize dental services and procedures for their effectiveness in improving or promoting ((~~children's~~)) dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for ((~~children's~~)) dental services are allocated to specific procedures based on the priorities identified in (c) of this subsection and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting ((~~children's~~)) dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the ((~~department's~~)) agency's evaluation of utilization trends, effectiveness of interventions, and access issues.

(3) ((~~MAA~~)) The agency reimburses dental general anesthesia services for eligible clients on the basis of base anesthesia units plus time. Payment for dental general anesthesia is calculated as follows:

(a) Dental procedures are assigned an anesthesia base unit of five;

(b) Fifteen minutes constitute one unit of time. When a dental procedure requiring dental general anesthesia results in multiple time units and a remainder (less than fifteen minutes), the remainder or fraction is considered as one time unit;

(c) Time units are added to the anesthesia base unit of five and multiplied by the anesthesia conversion factor;

(d) The formula for determining payment for dental general anesthesia is: (5.0 base anesthesia units + time units) x conversion factor = payment.

(4) When billing for anesthesia, the provider must show the actual beginning and ending times on the claim. Anesthesia time begins when the provider starts to physically prepare the client for the induction of anesthesia in the operating room area (or its equivalent), and ends when the provider is no longer in constant attendance (i.e., when the client can be safely placed under postoperative supervision).

(5) ((~~MAA~~)) The agency pays eligible providers listed in WAC ((~~388-535-1070~~)) 182-535-1070 for conscious sedation with parenteral and multiple oral agents, or for general anesthesia when the provider meets the criteria in this chapter and other applicable WAC.

(6) Dental hygienists who have a contract with ((~~MAA~~)) the agency are paid at the same rate as dentists who have a contract with ((~~MAA~~)) the agency, for services allowed under The Dental Hygienist Practice Act.

(7) Licensed denturists who have a contract with ((~~MAA~~)) the agency are paid at the same rate as dentists who have a contract with ((~~MAA~~)) the agency, for providing dentures and partials.

(8) ((~~MAA~~)) The agency makes fee schedule changes whenever the legislature authorizes vendor rate increases or decreases.

(9) ((~~MAA~~)) The agency may adjust maximum allowable fees to reflect changes in services or procedure code descriptions.

(10) ((~~MAA~~)) The agency does not pay separately for chart or record setup, or for completion of reports, forms, or charting. The fees for these services are included in ((~~MAA's~~)) the agency's reimbursement for comprehensive oral evaluations or limited oral evaluations.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1400 Payment for dental-related services. (1) The ((~~medical assistance administration (MAA)~~)) agency considers that a provider who furnishes covered dental services to an eligible client has accepted ((~~MAA's~~)) the agency's rules and fees.

(2) Participating providers must bill ((~~MAA~~)) the agency their usual and customary fees.

(3) Payment for dental services is based on ((~~MAA's~~)) the agency's schedule of maximum allowances. Fees listed in the ((~~MAA~~)) agency's fee schedule are the maximum allowable fees.

(4) ((~~MAA~~)) The agency pays the provider the lesser of the billed charge (usual and customary fee) or ((~~MAA's~~)) the agency's maximum allowable fee.

(5) ((~~MAA~~)) The agency pays "by report" on a case-by-case basis, for a covered service that does not have a set fee.

(6) Participating providers must bill a client according to WAC ((~~388-502-0160~~)) 182-502-0160, unless otherwise specified in this chapter.

(7) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partial dentures as described in WAC ((~~388-535-1240~~)) 182-535-1240 and ((~~388-535-1290~~)) 182-535-1290.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1450 Payment for denture laboratory services. This section applies to payment for denture laboratory services. The ((~~medical assistance administration (MAA)~~)) agency does not directly reimburse denture laboratories. ((~~MAA's~~)) The agency's reimbursement for complete dentures, ((~~immediate dentures,~~)) partial dentures, and overdentures includes laboratory fees. The provider is responsible to pay a denture laboratory for services furnished at the request of the provider.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1500 Payment for dental-related hospital services. The ((~~medical assistance administration (MAA)~~)) agency pays for medically necessary dental-related ((~~hospital~~)) services provided in an inpatient ((~~and~~)) or outpatient ((~~services in accord with~~)) hospital setting according to WAC ((~~388-550-1100~~)) 182-550-1100.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-535-1065	Coverage limits for dental-related services provided under the GA-U and ADATSA programs.
WAC 182-535-1247	Dental-related services for clients age twenty-one and older—General.
WAC 182-535-1255	Covered dental-related services—Adults.
WAC 182-535-1257	Covered dental-related services for clients age twenty-one and older—Preventive services.
WAC 182-535-1259	Covered dental-related services for clients age twenty-one and older—Restorative services.
WAC 182-535-1261	Covered dental-related services for clients age twenty-one and older—Endodontic services.
WAC 182-535-1263	Covered dental-related services for clients age twenty-one and older—Periodontic services.
WAC 182-535-1266	Covered dental-related services for clients age twenty-one and older—Prosthodontics (removable).
WAC 182-535-1267	Covered dental-related services for clients age twenty-one and older—Oral and maxillofacial surgery services.
WAC 182-535-1269	Covered dental-related services for clients age twenty-one and older—Adjunctive general services.
WAC 182-535-1271	Dental-related services not covered for clients age twenty-one and older.
WAC 182-535-1280	Obtaining prior authorization for dental-related services for clients age twenty-one and older.

WSR 12-06-042
PROPOSED RULES
YAKIMA VALLEY COMMUNITY COLLEGE
[Filed March 5, 2012, 9:00 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 12-03-071.

Title of Rule and Other Identifying Information: Chapter 132P-20 WAC, Yakima Valley Community College drug policy.

Hearing Location(s): M. L. King, Jr. Room, Hopf Union Building, Yakima Campus, South 16th Avenue and Nob Hill Boulevard, Yakima, Washington, on April 11, 2012, at 2:30 p.m.

Date of Intended Adoption: May 10, 2012.

Submit Written Comments to: Ms. Leslie Blackaby, Yakima Valley Community College (YVCC), P.O. Box 22520, Yakima, WA 98908-2520, e-mail lblackaby@yvcc.edu, fax (509) 574-6867, by April 10, 2012.

Assistance for Persons with Disabilities: Contact disabilities support services, YVCC, by April 10, 2011 [2012], TTY (relay service) (509) 574-4677 or (509) 574-4961.

Reasons Supporting Proposal: The proposal is to repeal chapter 132P-20 WAC, which was last updated in 1968. The information in chapter 132P-20 WAC is covered in chapter 132P-33 WAC, Student rights and responsibilities. Other related practices are described in the college catalog under the heading, Drug-Free Workplace Act of 1988, and in the college's collective bargaining agreements.

Statutory Authority for Adoption: RCW 28B.50.140.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: YVCC, public.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Leslie Blackaby, Deccio Higher Education Center, 1000 South 12th Avenue, Yakima, WA, (509) 574-6867.

No small business economic impact statement has been prepared under chapter 19.85 RCW. Repealer - no impact.

A cost-benefit analysis is not required under RCW 34.05.328. No impact.

March 5, 2012
Suzanne West
Rules Coordinator

REPEALER

The following chapter of the Washington Administrative Code is repealed:

Chapter 132P-20 WAC

WSR 12-06-044
PROPOSED RULES
TRANSPORTATION COMMISSION
[Filed March 5, 2012, 9:30 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 12-03-110.

Title of Rule and Other Identifying Information: WAC 468-300-040 Oversize vehicle ferry tolls.

Hearing Location(s): Cotton Tree Convention Center, San Juan Room, 2300 Market Street, Mount Vernon, WA 98273, on April 17, 2012, at 1:00 p.m. - 1:30 p.m.

Date of Intended Adoption: April 17, 2012.

Submit Written Comments to: Reema Griffith, Executive Director, Transportation Commission, 2404 Chandler Court S.W., Suite 270, Olympia, WA 98501, e-mail griffir@wstc.wa.gov, fax (360) 705-6802, by April 16, 2012.

Assistance for Persons with Disabilities: Contact transportation commission office by April 16, 2012, TTY (360) 705-7070.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: WAC 468-300-040 currently includes a commercial vehicle reservation fee for Washington state ferries' (WSF) routes in the San Juan Islands. WSF's proposed new reservation system includes the Port Townsend/Coupeville and Anacortes/Sidney, B.C. routes, and commercial vehicles for the domestic San Juan Islands routes. The new reservation system is anticipated to become effective in May 2012. In accordance with the guiding principle in the new system that reservations should not result in total cost above what that customer would have paid without reservations, the transportation commission proposes to delete a section in WAC 468-300-040 that currently requires a vehicle reservation fee for ferry routes in the San Juan Islands.

Reasons Supporting Proposal: In accordance with the guiding principle in WSF's new reservation system that reservations should not result in total cost above what that customer would have paid without reservations, the transportation commission proposes to delete a section in WAC 468-300-040 that currently requires a vehicle reservation fee for ferry routes in the San Juan Islands.

Statutory Authority for Adoption: RCW 47.56.030 and 47.60.315, and section 205(1), chapter 247, Laws of 2010.

Statute Being Implemented: RCW 47.56.030 and 47.60.315.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington state department of transportation ferries division, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Raymond G. Deardorf, 2901 Third Avenue, Suite 500, Seattle, WA 98121-3014, (206) 515-3491.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The commission has considered this rule and determined that it does not affect more than ten percent of one industry or twenty percent of all industry.

A cost-benefit analysis is not required under RCW 34.05.328. The transportation benefits to be achieved by instituting a state of the art reservation system for commercial vehicles in the San Juan Islands will far outweigh any fare revenue loss due to the elimination of the fee.

March 5, 2012
Reema Griffith
Executive Director

AMENDATORY SECTION (Amending WSR 11-18-034, filed 8/30/11, effective 10/1/11 and 5/1/12)

WAC 468-300-040 Oversize vehicle ferry tolls.

EFFECTIVE 03:00 A.M. October 1, 2011

Oversize Vehicle Ferry Tolls[1]
Overall Unit Length - Including Driver

ROUTES	22' To Under 30' Under 7'6" High[5]	22' To Under 30' Over 7'6" High[5]	30' To Under 40'[5]	40' To Under 50'[5]	50' To Under 60'[5]	60' To under 70'[5]	70' To and include 80'[5]	Cost Per Ft. Over 80' @
Fauntleroy-Southworth Port Townsend/Coupeville	14.65	29.30	39.35	49.45	59.50	69.60	79.70	1.00
Seattle-Bainbridge Island Seattle/Bremerton Edmonds-Kingston	19.05	38.15	51.25	64.40	77.50	90.65	103.75	1.30
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	24.40	48.80	65.60	82.40	99.20	116.00	132.80	1.70
Mukilteo-Clinton	11.20	22.40	30.15	37.85	45.55	53.30	61.00	0.75
*Anacortes to Lopez[2]	43.85	87.70	117.85	148.05	178.25	208.45	238.65	3.00
*Anacortes to Shaw, Orcas[2]	52.60	105.20	141.45	177.70	213.90	250.15	286.35	3.60
*Anacortes to Friday Harbor	62.55	125.05	168.10	211.15	254.20	297.25	340.30	4.30
Between Lopez, Shaw, Orcas and Friday Harbor[3]	29.35	58.70	78.90	99.15	119.35	139.55	159.80	N/A

Oversize Vehicle Ferry Tolls[1]
Overall Unit Length - Including Driver

ROUTES	22' To Under 30' Under 7'6" High[5]	22' To Under 30' Over 7'6" High[5]	30' To Under 40'[5]	40' To Under 50'[5]	50' To Under 60'[5]	60' To under 70'[5]	70' To and include 80'[5]	Cost Per Ft. Over 80' @
International Travel								
Anacortes to Sidney to all destinations - Recreational Vehicles and Buses	70.55	70.55	94.80	119.10	143.40	167.65	191.95	2.45
Anacortes to Sidney and Sidney to all destinations - Commercial Vehicles	70.55	141.05	189.60	238.20	286.75	335.30	383.90	4.85
Lopez, Shaw, Orcas and Friday Harbor to Sidney - Recreational Vehicles and Buses	21.15	21.15	28.40	35.70	42.95	50.20	57.50	0.75
- Commercial Vehicles	21.15	42.25	56.80	71.35	85.85	100.40	114.95	1.45
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[4] - Recreational Vehicles and Buses	91.70	91.70	123.20	154.80	186.35	217.85	249.45	3.20
- Commercial Vehicles	91.70	183.30	246.40	309.55	372.60	435.70	498.85	6.30

[1]OVERSIZE VEHICLES - Includes all vehicles 22 feet in length and longer regardless of type: Commercial trucks, recreational vehicles, vehicles under 22' pulling trailers, etc. Length shall include vehicle and load to its furthest extension. Overheight charge is included in oversize vehicle toll. Vehicles wider than 8'6" pay double the fare applicable to their length. Private and commercial passenger buses or other passenger vehicles pay the applicable oversize vehicle tolls. Public transit buses and drivers shall travel free upon display of an annual permit which may be purchased for $10. Upon presentation by either the driver or passenger of a WSF Disability Travel Permit, Regional Reduced Fare Permit, or other identification which establishes disability, vehicles 22-30 feet in length and over 7'6" in height shall be charged the 22-30 foot length and under 7'6" in height fare for vehicles equipped with wheelchair lift or other mechanism designed to accommodate the person with the disability.

[2]TRANSFERS - Tolls collected westbound only. Oversize vehicles traveling westbound from Anacortes may purchase a single intermediate transfer when first purchasing the appropriate fare. The transfer is valid for a 24-hour period and is priced as follows: $61.00 base season, $82.25 peak season.

[3]INTER-ISLAND - Tolls collected westbound only. Vehicles traveling between islands may request a single transfer ticket good for one transfer at an intermediate island. The transfer may only be obtained when purchasing the appropriate vehicle fare for inter-island travel (westbound at Lopez, Shaw, or Orcas) and is free of charge. Transfers shall be valid for 24 hours from time of purchase.

[4]ROUND TRIP - Round trip passage for international travel available for trips beginning or ending on one of the islands served.

[5]CAPITAL SURCHARGE - There will be an additional $0.25 capital surcharge on each single vehicle/driver fare collected.

VEHICLE RESERVATION DEPOSIT - Nonrefundable deposits for advanced reservations may be established at a level of from 25 to 100 percent of the applicable fare. This is a deposit toward the fare and not an additional fee, and applies only to those routes where the legislature has approved the use of a reservation system. Refunds may be available under certain special circumstances.

((~~COMMERCIAL VEHICLE RESERVATION FEES - For commercial vehicles traveling with reservations a participation fee ($200 for summer schedule season, $100 for each of the other schedule seasons) will be charged. Fees will be collected when reservations are confirmed.~~))

PEAK SEASON SURCHARGE - A peak season surcharge shall apply to all oversize vehicles from May 1 through September 30. The oversize fare shall be determined based on the peak-season car-and-driver fare and the analogous oversize vehicle fare, calculated with the same factor as the oversize base seasons fares are to the base season under 20 foot fare. The senior citizen discount shall apply to the driver of an oversize vehicle. The resulting fare is rounded up to the next $0.05 if required.

SENIOR CITIZEN DISCOUNTS - Discounts of 50% for the driver of the above vehicles shall apply. Senior citizen discount is determined by subtracting full-fare passenger rate and adding half-fare passenger rate. The senior citizen discount shall apply to the driver of an oversize vehicle.

PENALTY CHARGES - Owner of vehicle without driver will be assessed a $100.00 penalty charge.

DISCOUNT FROM REGULAR TOLL - Effective June 1, 2005, through fall of 2005, oversize vehicles making 12 or more, one-way crossings per week (Sunday through Saturday) will qualify for a 10% discount from the regular ferry tolls. With the implementation of EFS in spring 2006, WSF will provide a commercial account program that will be prepaid and offer access to volume discounts based on travel, revenue or other criteria in accordance with WSF business rules. On an annual basis, commercial accounts will pay a $50 nonrefundable account maintenance fee.

GROUP OR VOLUME SALES - In order to increase total revenues, WSF may develop full fare or discounted customer packages or bundle single fare types into multiple trip books or offer passes for high volume or group users. In pricing these packages, WSF will have discretion to set appropriate volume discounts based on a case-by-case basis.

SPECIAL EVENTS - In order to increase total revenues, WSF may develop, create or participate in special events that may include, but not be limited to, contributing or packaging discounted fares in exchange for the opportunity to participate in the income generated by the event.

FIRE DEPARTMENT AND FIRE DISTRICT FARE CONSIDERATION - At the discretion of the WSF Assistant Secretary, WSF may authorize no-fare or discounted fare passage on scheduled and/or special ferry sailings for fire departments and fire districts that provide contracted fire protection services for WSF ferry terminals and/or other WSF facilities within their jurisdiction. Such passage shall be considered full and complete consideration for such fire protection services, in lieu of annual payments for such services, to be so noted in such fire protection agreements. The scope of such authorization includes designated fire department and fire district vehicles (see below), drivers and passengers en route to and from an emergency call, on ferry routes with a WSF terminal and/or other WSF facility served by a fire department or fire district pursuant to a WSF fire protection service agreement. Authorized vehicles may include public fire department and fire

district medical aid units, fire trucks, incident command and/or other vehicles dispatched to and returning from an emergency call. WSF may implement such ferry passage on a pilot project basis to assess the operational, financial and administrative impact on WSF. By June 30, 2011, WSF shall submit a written report to the Transportation Commission identifying such impacts with a recommendation whether to make such passage authorization a permanent component of the WSF ferry toll schedule.

EMERGENCY TRIPS DURING NONSERVICE HOURS - While at locations where crew is on duty charge shall be equal to the cost of fuel consumed to make emergency trip. Such trips shall only be offered as a result of official requests from an emergency services agency and only in the case of no reasonable alternative.

DISCLAIMER - Under no circumstances does Washington state ferries warrant the availability of ferry service at a given date or time; nor does it warrant the availability of space on board a vessel on a given sailing.

EFFECTIVE 03:00 A.M. May 1, 2012

Oversize Vehicle Ferry Tolls[1]
Overall Unit Length - Including Driver

ROUTES	22' To Under 30' Under 7'6" High [5]	22' To Under 30' Over 7'6" High [5]	30' To Under 40'[5]	40' To Under 50'[5]	50' To Under 60'[5]	60' To under 70'[5]	70' To and include 80'[5]	Cost Per Ft. Over 80' @
Fauntleroy-Southworth Port Townsend/Coupeville	15.45	30.85	41.30	51.75	62.20	72.65	83.10	1.05
Seattle-Bainbridge Island Seattle/Bremerton Edmonds-Kingston	20.00	40.00	53.55	67.10	80.65	94.15	107.70	1.35
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	25.60	51.15	68.50	85.80	103.15	120.45	137.80	1.75
Mukilteo-Clinton	11.80	23.55	31.55	39.50	47.50	55.50	63.45	0.80
*Anacortes to Lopez[2]	45.95	91.90	123.05	154.20	185.30	216.45	247.60	3.10
*Anacortes to Shaw, Orcas[2]	55.20	110.35	147.75	185.10	222.50	259.90	297.25	3.75
*Anacortes to Friday Harbor	65.60	131.15	175.55	219.95	264.40	308.80	353.20	4.45
Between Lopez, Shaw, Orcas and Friday Harbor[3]	30.80	61.55	82.40	103.20	124.05	144.90	165.75	N/A
International Travel Anacortes to Sidney to all destinations - Recreational Vehicles and Buses	73.85	73.85	98.90	123.90	148.90	173.95	198.95	2.50
Anacortes to Sidney and Sidney to all destinations - Commercial Vehicles	73.85	147.70	197.75	247.80	297.80	347.85	397.90	5.00
Lopez, Shaw, Orcas and Friday Harbor to Sidney - Recreational Vehicles and Buses	22.10	22.10	29.60	37.05	44.55	52.00	59.50	0.75
- Commercial Vehicles	22.10	44.20	59.15	74.10	89.05	104.00	119.00	1.50
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[4] - Recreational Vehicles and Buses	95.95	95.95	128.50	160.95	193.45	225.95	258.45	3.25
- Commercial Vehicles	95.95	191.90	256.90	321.90	386.85	451.85	516.90	6.50

[1]OVERSIZE VEHICLES - Includes all vehicles 22 feet in length and longer regardless of type: Commercial trucks, recreational vehicles, vehicles under 22' pulling trailers, etc. Length shall include vehicle and load to its furthest extension. Overheight charge is included in oversize vehicle toll. Vehicles wider than 8'6" pay double the fare applicable to their length. Private and commercial passenger buses or other passenger vehicles pay the applicable oversize vehicle tolls. Public transit buses and drivers shall travel free upon display of an annual permit which may be purchased for $10. Upon presentation by either the driver or passenger of a WSF Disability Travel Permit, Regional Reduced Fare Permit, or other identification which establishes disability, vehicles 22-30 feet in length and over 7'6" in height shall be charged the 22-30 foot length and under 7'6" in height fare for vehicles equipped with wheelchair lift or other mechanism designed to accommodate the person with the disability.

[2]TRANSFERS - Tolls collected westbound only. Oversize vehicles traveling westbound from Anacortes may purchase a single intermediate transfer when first purchasing the appropriate fare. The transfer is valid for a 24-hour period and is priced as follows: $62.85 base season, $84.70 peak season.

[3]INTER-ISLAND - Tolls collected westbound only. Vehicles traveling between islands may request a single transfer ticket good for one transfer at an intermediate island. The transfer may only be obtained when purchasing the appropriate vehicle fare for inter-island travel (westbound at Lopez, Shaw, or Orcas) and is free of charge. Transfers shall be valid for 24 hours from time of purchase.

[4]ROUND TRIP - Round trip passage for international travel available for trips beginning or ending on one of the islands served.

[5]CAPITAL SURCHARGE - There will be an additional $0.25 capital surcharge on each single vehicle/driver fare collected.

VEHICLE RESERVATION DEPOSIT - Nonrefundable deposits for advanced reservations may be established at a level of from 25 to 100 percent of the applicable fare. This is a deposit toward the fare and not an additional fee, and applies only to those routes where the legislature has approved the use of a reservation system. Refunds may be available under certain special circumstances.

((~~COMMERCIAL VEHICLE RESERVATION FEES - For commercial vehicles traveling with reservations a participation fee ($200 for summer schedule season, $100 for each of the other schedule seasons) will be charged. Fees will be collected when reservations are confirmed.~~))

PEAK SEASON SURCHARGE - A peak season surcharge shall apply to all oversize vehicles from May 1 through September 30. The oversize fare shall be determined based on the peak-season car-and-driver fare and the analogous oversize vehicle fare, calculated with the same factor as the oversize base seasons fares are to the base season under 20 foot fare. The senior citizen discount shall apply to the driver of an oversize vehicle. The resulting fare is rounded up to the next $0.05 if required.

SENIOR CITIZEN DISCOUNTS - Discounts of 50% for the driver of the above vehicles shall apply. Senior citizen discount is determined by subtracting full-fare passenger rate and adding half-fare passenger rate. The senior citizen discount shall apply to the driver of an oversize vehicle.

PENALTY CHARGES - Owner of vehicle without driver will be assessed a $100.00 penalty charge.

DISCOUNT FROM REGULAR TOLL - Effective June 1, 2005, through fall of 2005, oversize vehicles making 12 or more, one-way crossings per week (Sunday through Saturday) will qualify for a 10% discount from the regular ferry tolls. With the implementation of EFS in spring 2006, WSF will provide a commercial account program that will be prepaid and offer access to volume discounts based on travel, revenue or other criteria in accordance with WSF business rules. On an annual basis, commercial accounts will pay a $50 nonrefundable account maintenance fee.

GROUP OR VOLUME SALES - In order to increase total revenues, WSF may develop full fare or discounted customer packages or bundle single fare types into multiple trip books or offer passes for high volume or group users. In pricing these packages, WSF will have discretion to set appropriate volume discounts based on a case-by-case basis.

SPECIAL EVENTS - In order to increase total revenues, WSF may develop, create or participate in special events that may include, but not be limited to, contributing or packaging discounted fares in exchange for the opportunity to participate in the income generated by the event.

FIRE DEPARTMENT AND FIRE DISTRICT FARE CONSIDERATION - At the discretion of the WSF Assistant Secretary, WSF may authorize no-fare or discounted fare passage on scheduled and/or special ferry sailings for fire departments and fire districts that provide contracted fire protection services for WSF ferry terminals and/or other WSF facilities within their jurisdiction. Such passage shall be considered full and complete consideration for such fire protection services, in lieu of annual payments for such services, to be so noted in such fire protection agreements. The scope of such authorization includes designated fire department and fire district vehicles (see below), drivers and passengers en route to and from an emergency call, on ferry routes with a WSF terminal and/or other WSF facility served by a fire department or fire district pursuant to a WSF fire protection service agreement. Authorized vehicles may include public fire department and fire district medical aid units, fire trucks, incident command and/or other vehicles dispatched to and returning from an emergency call. WSF may implement such ferry passage on a pilot project basis to assess the operational, financial and administrative impact on WSF. By June 30, 2011, WSF shall submit a written report to the Transportation Commission identifying such impacts with a recommendation whether to make such passage authorization a permanent component of the WSF ferry toll schedule.

EMERGENCY TRIPS DURING NONSERVICE HOURS - While at locations where crew is on duty charge shall be equal to the cost of fuel consumed to make emergency trip. Such trips shall only be offered as a result of official requests from an emergency services agency and only in the case of no reasonable alternative.

DISCLAIMER - Under no circumstances does Washington state ferries warrant the availability of ferry service at a given date or time; nor does it warrant the availability of space on board a vessel on a given sailing.

WSR 12-06-051
PROPOSED RULES
DEPARTMENT OF HEALTH

[Filed March 5, 2012, 10:43 a.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 246-320-199 Fees, hospital licensing fee increase.

Hearing Location(s): Department of Health, Point Plaza East, Room 152/153, 310 Israel Road S.E., Tumwater, WA 98501-7852, on April 19, 2012, at 9:30.

Date of Intended Adoption: May 3, 2012.

Submit Written Comments to: Barbara Runyon, P.O. Box 47852, Olympia, WA 98504-7852, e-mail barbara.runyon@doh.wa.gov, web site http://www3.doh.wa.gov/policyreview/, fax (360) 236-2901, by April 19, 2012.

Assistance for Persons with Disabilities: Contact Barbara Runyon by April 12, 2012, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule will increase licensing fees for hospitals. In 2011, the Washington state legislature adopted the 2011-2013 operating budget (2ESHB 1087, chapter 50, Laws of 2011 1st sp. sess.), giving the department authority to raise licensing fees. The fee increase is necessary to defray the costs of the hospital inspection program. The expenses in 2011-2013 biennium will exceed the projected revenue without the fee increase. State law (RCW 43.70.250) requires that business licensing programs be fully self supporting and directs the department to raise fees as necessary to meet the actual costs of operating the acute care hospital program.

Reasons Supporting Proposal: RCW 43.70.250 requires the cost of each licensing program be fully borne by the members of that business. The department is required to periodically adjust fees at a sufficient level to defray the costs of administering its programs. Expenses in the 2011-2013 biennium, including travel, rent and utilities will exceed the projected revenue. These fees are critical to ensuring the safety of patients accessing hospital care services.

Statutory Authority for Adoption: Chapter 43.70 RCW, 2ESHB 1087, (chapter 50, Laws of 2011 1st sp. sess.).

Statute Being Implemented: RCW 43.70.250, 2ESHB 1087, (chapter 50, Laws of 2011 1st sp. sess.).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of health, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Barbara Runyon, 310 Israel Road S.E., Tumwater, WA, (360) 236-2937.

No small business economic impact statement has been prepared under chapter 19.85 RCW. A small business eco-

nomic impact statement (SBEIS) was not prepared. Under RCW 19.85.025 and 34.05.310 (4)(f), an SBEIS is not required for proposed rules that set or adjust fees or rates pursuant to legislative standards.

A cost-benefit analysis is not required under RCW 34.05.328. The agency did not complete a cost-benefit analysis under RCW 34.05.328. RCW 34.05.328 (5)(b)(vi) exempts rules that set or adjust fees or rates pursuant to legislative standards.

March 5, 2012
Mary C. Selecky
Secretary

AMENDATORY SECTION (Amending WSR 09-07-050, filed 3/11/09, effective 4/11/09)

WAC 246-320-199 Fees. This section establishes the license and annual use fees for hospitals.

(1) Applicants must:

(a) Send the department an initial license fee of one hundred ((~~thirteen~~)) twenty-three dollars for each bed space within the authorized bed capacity for the hospital;

(b) Include all bed spaces in rooms complying with physical plant and movable equipment requirements of this chapter for twenty-four-hour assigned patient care;

(c) Include level 2 and 3 bassinet spaces;

(d) Include bed spaces assigned for less than twenty-four-hour patient use as part of the licensed bed capacity when:

(i) Physical plant requirements of this chapter are met without movable equipment; and

(ii) The hospital currently possesses the required movable equipment and certifies this fact to the department;

(e) Exclude all normal infant bassinets.

(2) Licensees shall:

(a) Send the department by November 30 of each year an annual use fee of one hundred ((~~thirteen~~)) twenty-three dollars for each bed space within the authorized bed capacity of the hospital;

(b) Include all bed spaces in rooms complying with physical plant and movable equipment requirements of this chapter for twenty-four-hour assigned patient rooms;

(c) Include level 2 and 3 bassinet spaces;

(d) Include bed spaces assigned for less than twenty-four-hour patient use as part of the licensed bed capacity when:

(i) Physical plant requirements of this chapter are met without movable equipment; and

(ii) The hospital currently possesses the required movable equipment and certifies this fact to the department;

(e) Exclude all normal infant bassinets; and

(f) Exclude beds banked as authorized by certificate of need under chapter 70.38 RCW.

(3) A licensee shall send a late fee in the amount of one hundred dollars per day whenever the annual use fee is not paid by November 30. The total late fee will not exceed twelve hundred dollars.

(4) An applicant may request a refund for initial licensure as follows:

(a) Two-thirds of the initial fee paid after the department has received an application and not conducted an on-site survey or provided technical assistance; or

(b) One-third of the initial fee paid after the department has received an application and conducted either an on-site survey or provided technical assistance but not issued a license.

WSR 12-06-052
PROPOSED RULES
DEPARTMENT OF HEALTH
[Filed March 5, 2012, 10:45 a.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 246-310-990, fees, certificate of need review fee increase.

Hearing Location(s): Point Plaza East, Room 152/153, 310 Israel Road S.E., Tumwater, WA 98501-7852, on April 19, 2012, at 11:00 a.m.

Date of Intended Adoption: April 26, 2012.

Submit Written Comments to: Janis Sigman, P.O. Box 47852, Olympia, WA 98504-7852, web site http://www3.doh.wa.gov/policyreview/, fax (360) 236-2901, by April 19, 2012.

Assistance for Persons with Disabilities: Contact Janis Sigman by April 12, 2012, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule increase review fees for certificate of need (CoN) applicants. The fees collected by CoN must cover the operational cost of the program, including: Performing reviews; providing technical assistance; conducting public hearings; defending appealed program and department decisions; rule development; and coordinating with state and local authorities. The department has seen a significant increase in appeals by applicants or affected persons. This has resulted in a significant increase in appeal costs in which the projected revenue is not anticipated to cover. In 2011, the Washington state legislature adopted the 2011-2013 operating budget (2ESHB 1087, chapter 50, Laws of 2011), giving the department authority to raise review fees.

Reasons Supporting Proposal: RCW 43.70.250 requires the cost of each licensing program be fully borne by members of that business. Over the past several biennia, fees have not consistently covered program costs. Current anticipated revenue is not sufficient to cover the costs of administering the CoN program. These fees will maintain the program at its current level and ensure that CoN decision[s] are made fairly, timely, and in a manner, to ensure needed facilities and new services are available within a particular region or community communities.

Statutory Authority for Adoption: Chapter 43.70 RCW, RCW 70.38.105(5), and 2ESHB 1087 (2011).

Statute Being Implemented: Chapter 43.70 RCW, RCW 70.38.105(5), and 2ESHB 1087 (2011).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of health, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Janis Sigman, 310 Israel Road S.E., Tumwater, WA, (360) 236-2956.

No small business economic impact statement has been prepared under chapter 19.85 RCW. A small business economic impact statement (SBEIS) was not prepared. Under RCW 19.85.025 and 34.05.310 (4)(f), an SBEIS is not required for proposed rules that set or adjust fees or rates pursuant to legislative standards.

A cost-benefit analysis is not required under RCW 34.05.328. The agency did not complete a cost-benefit analysis under RCW 34.05.328. RCW 34.05.328 (5)(b)(vi) exempts rules that set or adjust fees or rates pursuant to legislative standards.

March 5, 2012
Mary C. Selecky
Secretary

AMENDATORY SECTION (Amending WSR 08-12-036, filed 5/30/08, effective 7/1/08)

WAC 246-310-990 Certificate of need review fees. (1) An application for a certificate of need under chapter 246-310 WAC must include payment of a fee consisting of the following:

(a) A review fee based on the facility/project type;

(b) If more than one facility/project type applies to an application, the review fee for each type of facility/project must be included.

Facility/Project Type	Review Fee
Ambulatory Surgical Centers/Facilities	$((~~17,392.00~~)) 20,427.00
Amendments to Issued Certificates of Need	$((~~10,961.00~~)) 12,874.00
Emergency Review	$((~~7,055.00~~)) 8,286.00
Exemption Requests	
• Continuing Care Retirement Communities (CCRCs)/Health Maintenance Organization (HMOs)	$((~~7,055.00~~)) 8,286.00
• Bed Banking/Conversions	$((~~1,147.00~~)) 1,347.00
• Determinations of Nonreviewability	$((~~1,639.00~~)) 1,925.00
• Hospice Care Center	$((~~1,476.00~~)) 1,733.00
• Nursing Home Replacement/Renovation Authorizations	$((~~1,476.00~~)) 1,733.00
• Nursing Home Capital Threshold under RCW 70.38.105 (4)(e) (Excluding Replacement/Renovation Authorizations)	$((~~1,476.00~~)) 1,733.00
• Rural Hospital/Rural Health Care Facility	$((~~1,476.00~~)) 1,733.00
Extensions	
• Bed Banking	$((~~656.00~~)) 770.00
• Certificate of Need/Replacement Renovation Authorization Validity Period	$((~~656.00~~)) 770.00
Home Health Agency	$((~~21,001.00~~)) 24,666.00
Hospice Agency	$((~~18,704.00~~)) 21,968.00
Hospice Care Centers	$((~~10,961.00~~)) 12,874.00
Hospital (Excluding Transitional Care Units-TCUs, Ambulatory Surgical Center/Facilities, Home Health, Hospice, and Kidney Disease Treatment Centers)	$((~~34,457.00~~)) 40,470.00
Kidney Disease Treatment Centers	$((~~21,331.00~~)) 25,054.00
Nursing Homes (Including CCRCs and TCUs)	$((~~39,380.00~~)) 46,253.00

(2) The fee for amending a pending certificate of need application is determined as follows:

(a) If an amendment to a pending certificate of need application results in the addition of one or more facility/project types, the review fee for each additional facility/project type must accompany the amendment application;

(b) If an amendment to a pending certificate of need application results in the removal of one or more facility/project types, the department shall refund to the applicant the difference between the review fee previously paid and the review fee applicable to the new facility/project type; or

(c) If an amendment to a pending certificate of need application results in any other change as identified in WAC 246-310-100, a fee of ((~~one thousand seven hundred fifty-six~~)) two thousand sixty dollars must accompany the amendment application.

(3) If a certificate of need application is returned by the department under WAC 246-310-090 (2)(b) or (e), the department shall refund seventy-five percent of the review fees paid.

(4) If an applicant submits a written request to withdraw a certificate of need application before the beginning of review, the department shall refund seventy-five percent of the review fees paid by the applicant.

(5) If an applicant submits a written request to withdraw a certificate of need application after the beginning of review, but before the beginning of the ex parte period, the department shall refund one-half of all review fees paid.

(6) If an applicant submits a written request to withdraw a certificate of need application after the beginning of the ex parte period the department shall not refund any of the review fees paid.

(7) Review fees for exemptions and extensions are non-refundable.

WSR 12-06-057
PROPOSED RULES
DEPARTMENT OF TRANSPORTATION
[Filed March 5, 2012, 2:37 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 11-12-037.

Title of Rule and Other Identifying Information: WAC 468-300-700 Preferential loading.

Hearing Location(s): Washington State Ferries (WSF), 2901 Third Avenue, Suite 500, Seattle, WA 98121-3014, on April 11, 2012, at 1:00 p.m. - 2:00 p.m.

Date of Intended Adoption: April 11, 2012.

Submit Written Comments to: Ray Deardorf, WSF Planning Director, 2901 3rd Avenue, Suite 500, Seattle, WA 98121-3014, e-mail Deardorf@wsdot.wa.gov, fax (206) 515-3499, by April 10, 2012.

Assistance for Persons with Disabilities: Contact Susan Harris-Huether by April 10, 2012, TTY 771, ask for (206) 515-3460.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of the proposal is to review the preferential loading rules for WSF's routes and modify it to support the implementation of a new vehicle reservation system, plus responding to specific legislation concerning priority loading for health care workers in the San Juan Islands.

Positive effects from a state of the art reservation system are anticipated.

Reasons Supporting Proposal: Necessary to make modifications to support the implementation of an enhanced vehicle reservation system and to comply with state statute.

Statutory Authority for Adoption: RCW 47.56.030 and 47.60.315, and section 205(1), chapter 247, Laws of 2010.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington state department of transportation, ferries division, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Raymond G. Deardorf, 2901 Third Avenue, Suite 500, Seattle, WA 98121-3014, (206) 515-3491.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has considered this rule and determined that it does not affect more than ten percent of one industry or twenty percent of all industry.

A cost-benefit analysis is not required under RCW 34.05.328. WSF's long range plan of 2009 and the reservations predesign study of 2010 indicate substantial capital facility cost avoidance with the implementation of vehicle reservations, far in excess of the cost of implementing reservations.

March 5, 2012
Steve T. Reinmuth
Chief of Staff

AMENDATORY SECTION (Amending WSR 08-09-092, filed 4/18/08, effective 5/19/08)

WAC 468-300-700 Preferential loading. In order to protect public health, safety and commerce; to encourage more efficient use of the ferry system; and to reduce dependency on single occupant private automobiles:

(1) Preferential loading privileges on vessels operated by Washington state ferries (WSF), exempting vehicles from the standard first-come first-served rule, shall be granted in the order set forth below:

(a) An emergency medical vehicle, medical unit, aid unit, or ambulance dispatched to and returning from an emergency or nonemergency call while in service. Up to one additional vehicle may accompany a qualifying emergency medical vehicle or authorized med-evac when going to, but not when returning from, an emergency.

(b) A public police or fire vehicle only when responding to an emergency call, but not when returning from either an emergency or a nonemergency call. However, these vehicles will receive priority loading when they are returning from either an emergency or nonemergency call to Vashon Island or the San Juan Islands.

(c) A public utility or public utility support vehicle only when responding to an emergency call, but not when returning from either an emergency or a nonemergency call.

(d) Preferential loading may be granted for vehicles carrying passengers needing to accompany a family member who is being transported by an emergency vehicle, which requires the customer's timely access to the vessel's destination.

(e) Specific to routes without reservations where a vehicle occupant states that an extended wait would cause detrimental health risks to a vehicle occupant, that vehicle will be allowed preferential loading whenever the afflicted occupant has provided a medical form certified by a physician that such preferential loading is required.

However, when that vehicle occupant has not submitted the proper medical form, preferential loading will be permissible based upon appropriate terminal staff determination.

((~~(e) Preferential loading may be granted for vehicles carrying passengers needing to attend to a family member subject to risk of physical threat/harm or medical emergencies which requires the customer's timely access to the vessel's destination.~~))

(f) Specific to routes with reservations, where a vehicle occupant provides a medical form certified by a physician that the occupant is returning from a medical appointment or has been discharged from the hospital and that an extended wait would cause detrimental health risks, that vehicle will be allowed preferential treatment.

(g) Specific to routes with reservations (defined in subsections (4) through (10) of this section), a vehicle with a reservation, presenting proof of that reservation.

(h) Specific to routes with reservations available to all vehicles, vehicles identified in subsection (4)(a)(i) through (v) of this section receive preferential loading only if they have a reservation.

(i) A visibly marked school vehicle owned, operated, or sponsored by a school** when operating on regular schedules preapproved by the WSF or when advance notice is pro-

vided to each affected WSF terminal (**as defined in RCW 28A.150.010 (K-12), RCW 28A.150.020 (public schools), RCW 28A.195.010 (K-12 private schools), and RCW 28B.195.070 (secondary schools)).

((~~(g)~~)) (j) A visibly marked, preapproved or regularly scheduled publicly or privately owned public transportation vehicle** operating under a Washington state utilities and transportation commission certificate for public convenience and necessity (**as defined in RCW 81.68.010 (regular route/fixed termini), RCW 81.70.010 (charter and excursion)).

((~~(h)~~)) (k) A visibly marked nonprofit or publicly supported transportation vehicle** having provided each affected WSF terminal with advance notice and ((~~displaying~~)) presenting a WSF permit making it readily identifiable as a public transportation vehicle (**as defined in chapter 81.66 RCW (private, nonprofit special needs)).

((~~(i)~~)) (l) A visibly marked and randomly scheduled private for profit transportation vehicle** operating under a Washington state utilities and transportation commission certificate for public convenience and necessity traveling on routes where WSF is the only major access for land-based traffic only when that private for profit transportation vehicle has provided each affected WSF terminal with a preapproved schedule and/or advance notice of its proposed sailing(s), (**as defined in chapter 81.68 RCW (regular route/fixed termini), chapter 81.70 RCW (charter and excursion), chapter 81.66 RCW (private nonprofit special needs), chapter 46.72 RCW (private, for hire)).

((~~(j)~~)) (m) A ride-sharing vehicle for persons with special transportation needs** transporting a minimum of three elderly and/or disabled riders or two elderly and/or disabled riders and an attendant ((~~displaying~~)) presenting WSF rideshare registration program permit only when the operator of that vehicle has provided each affected WSF terminal with advance notice of its proposed sailing(s) (**as defined in RCW 46.74.010 (ride sharing for persons with special transportation needs)).

((~~(k)~~)) (n) A visibly marked, public ride-share vehicle** owned by a transit agency and leased out to members of the public through the transit agency's registration program only when the operator of that vehicle has provided each affected WSF terminal with advance notice of its proposed sailing(s) (**as defined in RCW 46.74.010 (commuter ride sharing)).

((~~(l)~~)) (o) A privately owned commuter ride-share vehicle** that visibly ((~~displays~~)) presents WSF approved identification markings readily identifiable by the public. There must be a minimum of three occupants in any such vehicle to receive preferential loading. Any such ride-share vehicle must be registered and in good standing in the WSF ride-share registration program (**as defined by RCW 46.74.010 (commuter ride sharing)).

((~~(m)~~)) (p) Specific to the Anacortes-San Juan Islands routes, a vehicle carrying livestock and traveling on routes where Washington state ferries is the only major access for land-based traffic, where such livestock (i) is raised for commercial purposes and is recognized by the department of agriculture, county agriculture soil and conservation service, as raised on a farm; or (ii) is traveling to participate in a 4H event sanctioned by a county extension agent.

((~~(n)~~)) (q) Specific to the Anacortes-San Juan Islands Interisland routes, home health care workers engaged in travel to and from patient visits.

(r) Specific to the Seattle-Bainbridge and Edmonds-Kingston ferry routes, where a vehicle occupant claims that an extended wait would cause detrimental health risks to their livestock en route to veterinarian services not available in the local community, that vehicle will be allowed preferential loading whenever the vehicle occupant has provided a medical form certified by a veterinarian that such preferential loading is required.

((~~(o)~~)) (s) Specific to the Fauntleroy-Vashon, Seattle-Bainbridge, Mukilteo-Clinton, and Anacortes-San Juan ferry routes, any mail delivery vehicle with proper documentation from the U.S. Postal Service showing that such vehicle is in the actual process of delivering mail.

((~~(p) Specific to the Anacortes-San Juan Islands routes, a vehicle 20 ft. and over in length and 10,000 lbs. or greater in weight, provided that the vehicle is carrying or returning from carrying article(s) of commerce for purchase or sale in commercial activity.~~

~~(q)~~)) (t) Vehicles 20 feet and over in length engaged in the conduct of commerce and/or transportation of passengers where and when WSF management has determined that the sale of vehicle space may promote higher utilization of available route capacity and an increase in revenues.

((~~(r)~~)) (u) An oversized or overweight vehicle (20 ft. and over in length, and/or over 8 1/2 ft. in width, and 80,000 lbs. or greater in weight) requiring transport at special times due to tidal conditions, vessel assignments, or availability of space.

((~~(s) As a pilot program during temporarily reduced service capacity, vehicles under 20 feet in length and passengers traveling with advance reservations on routes serving Port Townsend.~~

~~(t)~~)) (v) A scheduled bicycle group as determined by WSF only when a representative of that group has provided WSF with advance notice of the proposed travel schedule.

(2) Preferential loading privileges shall be subject to the following conditions:

(a) Privileges shall be granted only where physical facilities are deemed by WSF management to be adequate to allow granting the privilege and achieving an efficient operation.

(b) Subject to specified exceptions, documentation outlining qualifications for preferential loading and details of travel will be required in advance from all agencies, companies, or individuals requesting such privileges.

(c) Privileges may be limited to specified time periods as determined by WSF management.

(d) Privileges may require a minimum frequency of travel, as determined by WSF management.

(e) Privileges may be limited to a specific number of vehicle deck spaces and passenger capacity for any one sailing.

(f) Privileges may require arriving at the ferry terminal at a specified time prior to the scheduled sailing.

(3) To obtain more information about the documentation required and conditions imposed under subsection (2) of this section, call WSF's general information number, 206-464-

6400, or a terminal on a route for which the preferential boarding right is requested.

THE REMAINING SUBSECTIONS PROVIDE ADDITIONAL DETAILS ON VEHICLE RESERVATIONS, REFERENCED UNDER SUBSECTION (1) OF THIS SECTION.

(4) Vehicle reservation system intent.

(a) The intent of the vehicle reservation system is:

(i) To reduce queuing and congestion outside of ferry terminals;

(ii) To maximize the use of existing assets;

(iii) To provide enhanced customer service and travel predictability, spontaneity, and flexibility;

(iv) To manage demand by shifting discretionary trips from peak to off-peak sailings;

(v) To recognize the uniqueness of each different route;

(vi) To allow WSF flexibility to manage the system to best balance the needs of customers, communities, and WSF.

(b) Ferry customers are not required to make a reservation in order to travel on a Washington state ferry.

(5) Definitions.

(a) "Business account program member" is an individual or business who has an active business account with WSF.

(b) "Business reservation" is a vehicle reservation made by a business account program member.

(c) "General customer" is an individual or business that has purchased or is planning to purchase a reservation on a Washington state ferry and does not participate in WSF's business, premier, carpool, or vanpool reservations account programs.

(d) "General reservation" is a vehicle reservation made by a general customer.

(e) "Operational day" begins at 3:00 a.m. and ends at 2:59 a.m.

(f) "Premier account program member" is an individual who is currently enrolled in the premier account program.

(g) "Premier reservation" is a vehicle reservation made by a premier account program member.

(h) "Reservation holder" is a ferry customer who has acquired a vehicle reservation.

(i) "Reserved space" is space within the vehicle deck space available for vehicle reservations that has been secured by a customer by making a business, premier, or general reservation on that sailing.

(j) "Service interruption" is an event that causes WSF to not be able to run according to the published schedule.

(k) "Terms of use" refers to the agreement customers must read and agree to before their transaction to make a reservation is complete.

(l) "Unreservable space" is all space on a vessel that has not been reserved, or is not available to be reserved.

(m) "Vehicle deck space available for vehicle reservations" is the amount of vehicle deck space on a given vessel that WSF will allow to be reserved. All other space on the vessel is unreservable space.

(6) Modification of these regulations. WSF management reserves the right to add, delete, or modify portions of these regulations including the schedule of reservations charges and the terms of use in accordance with its regulations and applicable laws.

(7) Properties of a vehicle reservation.

(a) A vehicle reservation gives a ferry customer the right to travel at a specific date and time on a specific route with a vehicle of a specific size, as declared at the time of booking, subject to the priority loading conditions set forth in subsections (1) and (2) of this section. This right may be withdrawn at WSF's discretion due to service interruptions; or customer behavior that is inappropriate or dangerous.

(b) A vehicle reservation is not a ticket. Customers with reservations must purchase a ticket at the tollbooth of their departure terminal in order to travel on their reserved sailing.

(c) A vehicle reservation is not resalable to third parties.

(8) Vehicle reservation deposits.

(a) Vehicle reservation deposits may be collected at levels set by WSF management according to the rules set in WAC 468-300-020 (vehicle under 22', motorcycle, and stowage ferry tolls), and WAC 468-300-040 (oversize vehicle ferry tolls).

(b) Reservation deposits paid in advance will be applied toward the actual ticket cost for the reserved sailing at the departure terminal tollbooth. However, if a customer who has paid a reservation deposit is denied the ability to purchase a ticket for that reserved sailing due to priority loading conditions identified in subsections (1) and (2) of this section, then the customer may either seek a refund of the deposit, apply the deposit towards a ticket on the next scheduled sailing on the same route, or apply the deposit in accordance with (c) of this subsection. These are the sole and exclusive remedies available to a customer in these situations.

(c) Reservation deposits paid in advance may be applied toward the actual ticket cost of other, nonreserved sailings on the same route, as defined in the terms of use.

(9) Vessel space available for reservations.

(a) WSF has the authority to set the amount of tall and standard height vehicle deck space available for vehicle reservations on each sailing in order to achieve the intentions of the vehicle reservation system.

(b) For any given sailing, WSF may vary the amount of tall and standard height vehicle deck space available for vehicle reservations, depending on factors including, but not limited to:

(i) Time of day;

(ii) Day of week;

(iii) Season of year;

(iv) Direction of travel;

(v) Route;

(vi) Vessel size;

(vii) Level of demand; or

(viii) Level of congestion.

(c) For any given sailing, WSF may vary the distribution of tall and standard height vehicle deck space dedicated for business, premier, carpool or vanpool reservations; and dedicated to general reservations, depending on factors including, but not limited to:

(i) Time of day;

(ii) Day of week;

(iii) Season of year;

(iv) Direction of travel;

(v) Route;

(vi) Vessel size;

(vii) Level of demand; or

(viii) Level of congestion.

(d) WSF may change the distribution of unreservable space up until sailing departure.

(e) WSF may release vehicle deck space available for vehicle reservations up to one year in advance of a sailing. WSF may choose to phase the release of space on a particular sailing over time, as WSF management deems necessary to achieve the intent of the vehicle reservation system listed.

(f) Space may be made available for vehicle reservations for only certain reservation types (business account, premier account, carpool, vanpool, or general reservations).

(g) Space may be made available for a tentative sailing schedule if the final sailing schedule is not available.

(i) If departure times on the final sailing schedule are different than those on the tentative schedule, WSF will notify all affected reservation holders.

(ii) If the reserved sailing is canceled, WSF will notify the customer and refund any deposit paid.

(iii) All sailing schedules will be finalized at least six weeks before the schedule would take effect, and customers with affected reservations will be notified as soon as the schedule is final.

(h) Space allocations for specific reservation types (business account, premier account, carpool, vanpool, or general reservations) may be changed by WSF at any point in time up until sailing departure.

(10) Reservation system during service interruptions.

(a) During a ferry service interruption, WSF management may temporarily adjust business and operational rules to address the issue until normal service is restored. This may include, but is not limited to:

(i) Canceling existing reservations;

(ii) Not allowing new reservations; or

(iii) Changing existing reservations to other sailings. (b) Upon canceling or moving a reservation, WSF will notify the affected customers via e-mail or phone.

(c) Customers will not be charged for any changes or cancellations resulting from service interruptions.

(d) If a customer's reserved sailing has been canceled or significantly delayed and the customer can no longer travel that operational day, any deposit paid will be refunded, which shall be the sole and exclusive remedy available to the customer in such situations.

(e) During service interruptions, WSF may turn customers without reservations away from the terminal.

(f) During service interruptions, WSF may not be able to guarantee travel for reservation holders.

WSR 12-06-059

PROPOSED RULES

DEPARTMENT OF FINANCIAL INSTITUTIONS

(Securities Division)

[Filed March 5, 2012, 2:52 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 12-03-115.

Title of Rule and Other Identifying Information: The securities division is proposing to amend certain WAC sections in order to correct references made to definitions found in the Securities Act of Washington, RCW 21.20.005. The division is not seeking to revise the definitions themselves. Recently, the office of the code reviser revised the definitions section of the Securities Act of Washington, RCW 21.20.005, by alphabetizing the defined terms. This reordering resulted in a renumbering of the defined terms in this section. As a result, the WAC now contains several inaccurate references. The division is proposing rule making to correct these inaccuracies.

Hearing Location(s): State of Washington, Department of Financial Institutions (DFI), 150 Israel Road S.W., Room 319, Tumwater, WA 98501, on April 10, 2012, at 2:00 p.m.

Date of Intended Adoption: April 11, 2012.

Submit Written Comments to: Dan Matthews, Department of Financial Institutions, Securities Division, P.O. Box 9033, Olympia, WA 98507-9033, e-mail don.matthews@dfi.wa.gov, fax (360) 704-6496, by April 10, 2012.

Assistance for Persons with Disabilities: Contact Carolyn Hawkey, P.O. Box 9033, Olympia, WA 98507-9033, by March 17, 2010 [2012], TTY (360) 664-8126 or (360) 902-8824.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: RCW 21.20.005 was revised by the office of the code reviser pursuant to RCW 1.08.015 (2)(k). This revision resulted in a renumbering of the definitions found in RCW 21.20.005. As a result, the WAC now contains several inaccurate references. The proposed rule making would correct these inaccuracies by removing the paragraph number from each reference in the WAC to the definitions in RCW 21.20.005. The division is proposing amending WAC 460-10A-215, 460-20B-035, 460-24A-020, 460-24A-045, 460-33A-010, 460-33A-015, and 460-44A-501.

Reasons Supporting Proposal: The proposed rule making is beneficial to regulated entities, local governments, and small businesses that rely on the WAC. In its current form, the code could confuse and mislead regulated entities, leading to added time and costs to both the government and the public. Further, the inaccuracies may create miscommunications between our agency and those we regulate, which could lead to added costs and less effective regulation. By engaging in this rule making, the government and the public will be benefited through more efficient and accurate regulation and communication.

Statutory Authority for Adoption: RCW 21.20.450.

Statute Being Implemented: Chapter 21.20 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: DFI, governmental.

Name of Agency Personnel Responsible for Drafting: Dan Matthews, 150 Israel Road S.W., Tumwater, WA 98501, (360) 902-8760; Implementation: Scott Jarvis, Director, 150 Israel Road S.W., Tumwater, WA 98501, (360) 902-8760; and Enforcement: William M. Beatty, Director of Securities,

150 Israel Road S.W., Tumwater, WA 98501, (360) 902-8760.

No small business economic impact statement has been prepared under chapter 19.85 RCW. If any costs are borne by businesses in connection with the proposed rules, these costs will be no more than minor. As such, the agency is not required to prepare a small business economic impact statement under RCW 19.85.030.

A cost-benefit analysis is not required under RCW 34.05.328. DFI is not one of the agencies listed in RCW 34.05.328.

March 5, 2012
Scott Jarvis
Director

AMENDATORY SECTION (Amending WSR 02-18-044, filed 8/28/02, effective 9/28/02)

WAC 460-10A-215 Security—Viatical and life settlement agreements. (1) A viatical or life settlement agreement constitutes a security if the agreement falls within the definition of "security" under RCW 21.20.005((~~(12)~~)) as an investment contract; an investment of money or other consideration in the risk capital of a venture with the expectation of some valuable benefit to the investor where the investor does not receive the right to exercise practical and actual control over the managerial decisions of the venture; or otherwise.

(2) For purpose of this section, a "viatical or life settlement agreement" means an agreement for consideration for the purchase, assignment, transfer, sale, devise or bequest of any portion of the death benefit under, or ownership of, either an insurance policy or certificate of insurance. A viatical or life settlement agreement does not include:

(a) Any agreement for the original issuance of an insurance policy or certificate of insurance;

(b) An assignment, transfer, sale, devise or bequest of a death benefit under, or ownership of, either an insurance policy or certificate of insurance by the original owner, or a person who has an insurable interest in the insured, to any of the following:

(i) The insured;

(ii) A person who has an insurable interest in the insured;

(iii) A dealer; or

(iv) A person who is engaged in the business of purchasing the death benefit under, or ownership of, either insurance policies or certificates of insurance;

(c) An assignment of an insurance policy or certificate of insurance to any bank, savings bank, savings and loan association, credit union, or other licensed lending institution as collateral for a loan; or

(d) The exercise of accelerated benefits pursuant to the life insurance policy.

AMENDATORY SECTION (Amending WSR 96-15-062, filed 7/17/96, effective 8/17/96)

WAC 460-20B-035 Canadian broker-dealers and salespersons. (1) A Canadian broker-dealer that is resident in Canada and has no office or other physical presence in the United States and is not an office of, branch of, or a natural person associated with, a broker-dealer otherwise registered in the United States may transact business in this state without registering as a broker-dealer pursuant to RCW 21.20.040 under the following conditions:

(a) The business transacted by the Canadian broker-dealer must be limited to:

(i) Transactions subject to the exemption provided by RCW 21.20.320(8);

(ii) Transactions with or for a Canadian person who is temporarily present in this state and with whom the Canadian broker-dealer had a bona fide customer relationship before the person entered this state; or

(iii) Transactions with or for a Canadian person in a self-directed tax advantaged retirement plan in Canada of which that person is the holder or contributor; and

(b) The Canadian broker-dealer must:

(i) File the following with the securities administrator:

(A) A notice in the form of that person's current application for registration required by the jurisdiction in which that person's head office is located; and

(B) A consent to service process pursuant to RCW 21.20.330; and

(ii) Be a member of a self-regulatory organization or stock exchange in Canada; and

(iii) Maintain provincial or territorial registration and membership in a Canadian self-regulatory organization or stock exchange in good standing; and

(c) Disclosure must be made to the customers in this state that the Canadian broker-dealer is not subject to the full regulatory requirements of the Securities Act of Washington.

(2) A Canadian securities salesperson representing a Canadian broker-dealer transacting business in this state pursuant to subsection (1) of this section need not register pursuant to RCW 21.20.040 provided that he or she is registered in good standing in the appropriate Canadian jurisdiction.

(3) Transactions by Canadian broker-dealers and their salespersons pursuant to subsections (1) and (2) of this section will be deemed not to involve the "offer" or "sale" of a security, as those terms are defined in RCW 21.20.005((~~(10)~~)), for purposes of compliance with RCW 21.20.140. Nothing in this section shall affect the duty of the Canadian broker-dealer and its agents to comply with RCW 21.20.010 and the rules promulgated thereunder.

AMENDATORY SECTION (Amending WSR 01-16-125, filed 7/31/01, effective 10/24/01)

WAC 460-24A-020 Investment adviser representatives employed by federal covered advisers. An individual employed by or associated with a federal covered adviser is an "investment adviser representative," pursuant to RCW 21.20.005((~~(14)~~)), if the representative has a "place of business" in this state, as that term is defined under section 203A of the Investment Advisers Act of 1940, and:

(1) Is an "investment adviser representative" pursuant to the Investment Advisers Act of 1940; or

(2) Solicits, offers, or negotiates for the sale of or sells investment advisory services on behalf of a federal covered adviser, but is not a "supervised person" as that term is defined under the Investment Advisers Act of 1940.

AMENDATORY SECTION (Amending WSR 97-16-050, filed 7/31/97, effective 8/31/97)

WAC 460-24A-045 Holding out as a financial planner. A person using a term deemed similar to "financial planner" or "investment counselor" under WAC 460-24A-040(2) will not be considered to be holding himself out as a financial planner for purposes of RCW 21.20.005((~~6~~)) and 21.20.040 under the following circumstances:

(1) The person is not in the business of providing advice relating to the purchase or sale of securities, and would not, but for his use of such a term, be an investment adviser required to register pursuant to RCW 21.20.040; and

(2) The person does not directly or indirectly receive a fee for providing investment advice. Receipt of any portion of a "wrap fee," that is, a fee for some combination of brokerage and investment advisory services, constitutes receipt of a fee for providing investment advice for the purpose of this section; and

(3) The person delivers to every customer, at least forty-eight hours before accepting any compensation, including commissions from the sale of any investment product, a written disclosure including the following information:

(a) The person is not registered as an investment adviser or investment adviser salesperson in the state of Washington;

(b) The person is not authorized to provide financial planning or investment advisory services and does not provide such services; and

(c) A brief description the person's business which description should include a statement of the kind of products offered or services provided (e.g., the person is in the business of selling securities and insurance products) and of the basis on which the person is compensated for the products sold or services provided; and

(4) The person has each customer to whom a disclosure described in subsection (3) of this section is given sign a written dated acknowledgment of receipt of the disclosure; and

(5) The person shall retain the executed acknowledgments of receipt required by subsection (4) of this section and of the disclosure given for so long as the person continues to receive compensation from such customers, but in no case for less than three years from date of execution of the acknowledgment;

(6) If the person received compensation from the customer on more than one occasion, the person need give the customer the disclosure described in subsection (3) of this section only on the first occasion unless the information in the disclosure becomes inaccurate, in which case the person must give the customer updated disclosure before receiving further compensation from the customer.

AMENDATORY SECTION (Amending WSR 01-23-002, filed 11/7/01, effective 12/8/01)

WAC 460-33A-010 Application. (1) The rules contained in these regulations are intended to offer an optional method for the registration of "mortgage paper securities" as defined in WAC 460-33A-015(4). While applications for registration not conforming to the standards contained herein shall be looked upon with disfavor, where good cause is shown, certain rules of this chapter may be modified or waived by the director, if consistent with the spirit of these rules.

(2) The application of these rules does not affect those issuers to which or to whom the debenture company sections of the Securities Act apply.

(3) These rules do not affect the statutory exemptions provided for by, nor will they be applied to, those securities or transactions exempt under RCW 21.20.310 or 21.20.320. These rules are not intended to expand or restrict the definition of "security" as defined in RCW 21.20.005((~~12~~)).

(4) The rules contained in this chapter are only applicable to mortgage paper securities, mortgage broker-dealers and mortgage salespersons registering under this chapter.

AMENDATORY SECTION (Amending WSR 01-23-002, filed 11/7/01, effective 12/8/01)

WAC 460-33A-015 Definitions. As used in this chapter:

(1) "Mortgage broker-dealer" means a person who is defined as a "broker-dealer" in RCW 21.20.005((~~3~~)) and who effects transactions in mortgage paper securities registered under the provisions of this chapter.

(2) "General offering circular" means a disclosure document that gives a general description of what is involved in the purchase of mortgage paper securities and the business of offering the mortgage paper securities including a description of the mortgage broker-dealer.

(3) "Mortgage salesperson" means a person other than a mortgage broker-dealer who is defined as a "salesperson" in RCW 21.20.005((~~2~~)) and who represents a mortgage broker-dealer in effecting offers or sales of mortgage paper securities registered under the provisions of this chapter.

(4) "Mortgage paper securities" means notes and bonds, or other debt securities secured by mortgages or trust deeds on real or personal property or by a vendor's interest in a property sales contract or options granting the right to purchase any of the foregoing, including any guarantee of or interest in the foregoing.

(5) "Specific offering circular" means a disclosure document describing the specific mortgage paper securities offering, which is meant to accompany the general offering circular.

(6) "Financial institution" means any bank, trust company, savings bank, national banking association, savings and loan association, building and loan association, mortgage banker, credit union, insurance company, or other similarly regulated financial institution, or holding company for any of the foregoing.

(7) "Construction loan" means a loan in which twenty-five percent or more of the loan proceeds will be used to fund future improvements to real estate securing the loan.

(8) "Income-producing properties" means real property that produces income on a regular basis.

AMENDATORY SECTION (Amending WSR 11-01-139, filed 12/21/10, effective 1/21/11)

WAC 460-44A-501 Definitions and terms. As used in rules WAC 460-44A-501 through 460-44A-508, the following terms shall have the meaning indicated:

(1) "Accredited investor" shall mean any person who comes within any of the following categories, or who the issuer reasonably believes comes within any of the following categories, at the time of the sale of the securities to that person:

(a) Any bank as defined in section 3 (a)(2) of the Securities Act of 1933, or any savings and loan association or other institution as defined in section 3 (a)(5)(A) of the Securities Act of 1933 whether acting in its individual or fiduciary capacity; any broker or dealer registered pursuant to section 15 of the Securities Exchange Act of 1934; any insurance company as defined in section 2(13) of the Securities Act of 1933; any investment company registered under the Investment Company Act of 1940 or a business development company as defined in section 2 (a)(48) of that act; any small business investment company licensed by the U.S. Small Business Administration under section 301 (c) or (d) of the Small Business Investment Act of 1958; any plan established and maintained by a state, its political subdivisions, or any agency or instrumentality of a state or its political subdivisions, for the benefit of its employees, if such plan has total assets in excess of $5,000,000; any employee benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 if the investment decision is made by a plan fiduciary, as defined in section 3(21) of such act, which is either a bank, savings and loan association, insurance company, or registered investment adviser, or if the employee benefit plan has total assets in excess of $5,000,000 or, if a self-directed plan, with investment decisions made solely by persons that are accredited investors;

(b) Any private business development company as defined in section 202 (a)(22) of the Investment Advisers Act of 1940;

(c) Any organization described in section 501 (c)(3) of the Internal Revenue Code, corporation, Massachusetts or similar business trust, or partnership, not formed for the specific purpose of acquiring the securities offered, with total assets in excess of $5,000,000;

(d) Any director, executive officer, or general partner of the issuer of the securities being offered or sold, or any director, executive officer, or general partner of a general partner of that issuer;

(e) Any natural person whose individual net worth, or joint net worth with that person's spouse, at the time of his purchase exceeds $1,000,000 excluding the value of the primary residence of such natural person;

(f) Any natural person who had an individual income in excess of $200,000 in each of the two most recent years or joint income with that person's spouse in excess of $300,000 in each of those years and has a reasonable expectation of reaching the same income level in the current year;

(g) Any trust, with total assets in excess of $5,000,000, not formed for the specific purpose of acquiring the securities offered, whose purchase is directed by a sophisticated person as described in 17 CFR Sec. 230.506 (b)(2)(ii); and

(h) Any entity in which all of the equity owners are accredited investors.

(2) "Affiliate" an "affiliate" of, or person "affiliated" with, a specified person shall mean a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified;

(3) "Aggregate offering price" shall mean the sum of all cash, services, property, notes, cancellation of debt, or other consideration to be received by an issuer for issuance of its securities. Where securities are being offered for both cash and noncash consideration, the aggregate offering price shall be based on the price at which the securities are offered for cash. Any portion of the aggregate offering price attributable to cash received in a foreign currency shall be translated into United States currency at the currency exchange rate in effect at a reasonable time prior to or on the date of the sale of the securities. If securities are not offered for cash, the aggregate offering price shall be based on the value of the consideration as established by bona fide sales of that consideration made within a reasonable time, or, in the absence of sales, on the fair value as determined by an accepted standard. Such valuations of noncash consideration must be reasonable at the time made;

(4) "Business combination" shall mean any transaction of the type specified in paragraph (a) of Rule 145 under the Securities Act of 1933 and any transaction involving the acquisition by one issuer, in exchange for all or a part of its own or its parent's stock, of stock of another issuer if, immediately after the acquisition, the acquiring issuer has control of the other issuer (whether or not it had control before the acquisition);

(5) "Calculation of number of purchasers." For purposes of calculating the number of purchasers under WAC 460-44A-504 and 460-44A-505 the following shall apply:

(a) The following purchasers shall be excluded:

(i) Any relative, spouse or relative of the spouse of a purchaser who has the same principal residence as the purchaser;

(ii) Any trust or estate in which a purchaser and any of the persons related to him as specified in WAC 460-44A-501 (5)(a)(i) or (iii) collectively have more than fifty percent of the beneficial interest (excluding contingent interests);

(iii) Any corporation or other organization of which a purchaser and any of the persons related to him as specified in WAC 460-44A-501 (5)(a)(i) or (ii) collectively are beneficial owners of more than fifty percent of the equity securities (excluding directors' qualifying shares) or equity interests; and

(iv) Any accredited investor.

(b) A corporation, partnership or other entity shall be counted as one purchaser. If, however, that entity is organized for the specific purpose of acquiring the securities offered and is not an accredited investor under WAC 460-44A-501 (1)(h), then each beneficial owner of equity securities or equity interests in the entity shall count as a separate purchaser for all provisions of WAC 460-44A-501 through 460-44A-508, except to the extent provided in (a) of this subsection.

(c) A noncontributory employee benefit plan within the meaning of Title I of the Employee Retirement Income Security Act of 1974 shall be counted as one purchaser where the trustee makes all investment decisions for the plan.

Note: The issuer must satisfy all the other provisions of WAC 460-44A-501 through 460-44A-505 for all purchasers whether or not they are included in calculating the number

of purchasers. Clients of an investment adviser or customers of a broker-dealer shall be considered the "purchasers" under WAC 460-44A-501 through 460-44A-505 regardless of the amount of discretion given to the investment adviser or broker-dealer to act on behalf of the client or customer.

(6) "Executive officer" shall mean the president, any vice-president in charge of a principal business unit, division or function (such as sales, administration or finance), or any other officer who performs a policy making function, or any other person who performs similar policy making functions for the issuer. Executive officers of subsidiaries may be deemed executive officers of the issuer if they perform such policy making functions for the issuer.

(7) "Issuer" as defined in Section 2(4) of the Securities Act of 1933 or RCW 21.20.005((~~(7)~~)) shall apply, except that in the case of a proceeding under the Federal Bankruptcy Code (11 U.S.C. 101 et seq.), the trustee or debtor in possession shall be considered the issuer in an offering under a plan or reorganization, if the securities are to be issued under the plan.

(8) "Purchaser representative" shall mean any person who satisfies all of the following conditions or who the issuer reasonably believes satisfies all of the following conditions:

(a) Is not an affiliate, director, officer or other employee of the issuer, or beneficial owner of ten percent or more of any class of the equity securities or ten percent or more of the equity interest in the issuer, except where the purchaser is:

(i) A relative of the purchaser representative by blood, marriage or adoption and not more remote than a first cousin;

(ii) A trust or estate in which the purchaser representative and any person related to him as specified in WAC 460-44A-501 (8)(a)(i) or (iii) collectively have more than fifty percent of the beneficial interest (excluding contingent interest) or of which the purchaser representative serves as trustee, executor, or in any similar capacity; or

(iii) A corporation or other organization of which the purchaser representative and any persons related to him as specified in WAC 460-44A-501 (8)(a)(i) or (ii) collectively are the beneficial owners of more than 50 percent of the equity securities (excluding directors' qualifying shares) or equity interests;

(b) Has such knowledge and experience in financial and business matters that he is capable of evaluating, alone, or together with other purchaser representatives of the purchaser, or together with the purchaser, the merits and risks of the prospective investment;

(c) Is acknowledged by the purchaser in writing, during the course of the transaction, to be his purchaser representative in connection with evaluating the merits and risks of the prospective investment; and

(d) Discloses to the purchaser in writing a reasonable time prior to the sale of securities to that purchaser any material relationship between himself or his affiliates and the issuer or its affiliates that then exists, that is mutually understood to be contemplated, or that has existed at any time during the previous two years, and any compensation received or to be received as a result of such relationship.

Note 1: A person acting as a purchaser representative should consider the applicability of the registration and anti-fraud provisions relating to broker-dealers under chapter 21.20 RCW and the Securities Exchange Act of 1934 (15 U.S.C. 78a et seq., as amended) and relating to investment advisers under chapter 21.20 RCW and the Investment Advisers Act of 1940.

Note 2: The acknowledgment required by paragraph (8)(c) and the disclosure required by paragraph (8)(d) of this WAC 460-44A-501 must be made with specific reference to each prospective investment. Advance blanket acknowledgment, such as for "all securities transactions" or "all private placements," is not sufficient.

Note 3: Disclosure of any material relationships between the purchaser representative or his affiliates and the issuer or its affiliates does not relieve the purchaser representative of his obligation to act in the best interest of the purchaser.

WSR 12-06-061
PROPOSED RULES
DEPARTMENT OF HEALTH
(Board of Nursing Home Administrators)

[Filed March 5, 2012, 3:49 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 11-19-012.

Title of Rule and Other Identifying Information: WAC 246-843-010 General definitions and 246-843-205 Standards of conduct for nursing home administrators. Amending the rules to clarify that standards for nursing home administrators do not change even when a licensed nursing facility converts some of its beds to assisted living beds.

Hearing Location(s): Department of Health, Point Plaza East, Room 153, 310 Israel Road S.E., Tumwater, WA 98501, on May 4, 2012, at 11:00 a.m.

Date of Intended Adoption: May 4, 2012.

Submit Written Comments to: Kendra Pitzler, P.O. Box 47864, Olympia, WA 98504-7864, web site http://www3.doh.wa.gov/policyreview/, fax (360) 236-2901, by April 27, 2012.

Assistance for Persons with Disabilities: Contact Kendra Pitzler by April 20, 2012, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Legislation (ESSB 5708) passed in 2011 requires the board to adopt rules defining an on-site full-time administrator in nursing homes with small resident populations when the nursing home has converted some of its licensed nursing facility bed capacity for use as assisted living or enhanced assisted living services under chapter 74.39A RCW. The proposed rule allows a nursing home administrator to also be the administrator of the assisted living facility when one facility has both types of beds. The proposal add[s] this type of facility to the current definition.

Reasons Supporting Proposal: The proposed rule is required by ESSB 5708. The proposed rule ensures that a nursing home administrator who is the administrator of a nursing home that has both nursing home and assisted living beds understands the amount of time he or she is required to spend in the nursing home administrator role.

Statutory Authority for Adoption: ESSB 5708, RCW 18.52.030.

Statute Being Implemented: RCW 18.52.030.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Board of nursing home administrators, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Kendra Pitzler, 310 Israel Road SE, Tumwater, WA 98501, (360) 236-4723.

No small business economic impact statement has been prepared under chapter 19.85 RCW. A small business impact statement was not prepared. The proposed rule would not impose more than minor costs on businesses in an industry.

A cost-benefit analysis is not required under RCW 34.05.328. The agency did not complete a cost-benefit analysis under RCW 34.05.328. The proposed rule does not qualify as a significant legislative rule because it does not adopt substantive provisions of the law. The amendments simply provide clarification and do not change the existing standards.

March 5, 2012
Blake T. Maresh
Executive Director

AMENDATORY SECTION (Amending WSR 00-01-071, filed 12/13/99, effective 1/13/00)

WAC 246-843-010 General definitions. Terms used in these rules have the following meanings:

(1) "On-site, full-time administrator" is an individual in active administrative charge of one nursing home facility or collocated facilities, as licensed under chapter 18.51 RCW, a minimum of four days and an average of forty hours per week. ((~~Exception:~~)) An "on-site, full-time administrator" in nursing homes with small resident populations, ((~~or~~)) in rural areas, or in nursing homes with small resident populations when the nursing home has converted some of its licensed nursing facility bed capacity for use as assisted living or enhanced assisted living services under chapter 74.39A RCW is an individual in active administrative charge of one nursing home facility, or collocated facilities, as licensed under chapter 18.51 RCW:

(a) A minimum of four days and an average of twenty hours per week at facilities with one to thirty nursing home beds; or

(b) A minimum of four days and an average of thirty hours per week at facilities with thirty-one to forty-nine nursing home beds.

(2) "Active administrative charge" is direct participation in the operating concerns of a nursing home. Operating concerns include, but are not limited to, interaction with staff and residents, liaison with the community, liaison with regulatory agencies, pertinent business and financial responsibilities, planning and other activities as identified in the most current job analysis published by the National Association of Boards of Examiners for Long-Term Care Administrators.

(3) "Person" means an individual and does not include the terms firm, corporation, institutions, public bodies, joint stock associations, and other such entities.

(4) "Nursing home administrator-in-training" means an individual in an administrator-in-training program approved by the board.

(5) "Secretary" means the secretary of the department of health or the secretary's designee.

(6) "Collocated facilities" means more than one licensed nursing facility situated on a contiguous or adjacent property, whether or not there are intersecting streets. Other criteria to qualify as a collocated facility would be determined by the nursing home licensing agency under chapter 18.51 RCW.

(7) "Recognized institution of higher learning" means an accredited degree granting institution in the United States or outside the United States that is listed in the directory of accredited institutions of postsecondary education published by the American Council on Education.

AMENDATORY SECTION (Amending WSR 00-01-067, filed 12/13/99, effective 1/13/00)

WAC 246-843-205 Standards of conduct. Licensed nursing home administrators shall be on-site full time as defined in WAC 246-843-010(1) and in active administrative charge of the licensed nursing home, as licensed under chapter 18.51 RCW, in which they have consented to serve as administrator.

WSR 12-06-067
PROPOSED RULES
DEPARTMENT OF LABOR AND INDUSTRIES
[Filed March 6, 2012, 9:21 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 12-03-092.

Title of Rule and Other Identifying Information: Chapter 296-46B WAC, Electrical safety standards, administration, and installation.

Hearing Location(s): Department of Labor and Industries (L&I), 7273 Linderson Way S.W., Room S119, Tumwater, WA 98501, on April 10, 2012, at 9:00 a.m.

Date of Intended Adoption: May 22, 2012.

Submit Written Comments to: Sally Elliott, P.O. Box 44400, Olympia, WA 98504-4400, e-mail sally.elliott@lni.wa.gov, fax (360) 902-5292, by 5 p.m. on April 10, 2012.

Assistance for Persons with Disabilities: Contact Sally Elliott by March 20, 2012, at sally.elliott@lni.wa.gov or (360) 902-6411.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this rule making is to increase the fees for the electrical program. The electrical program's budget and projected revenue indicate a fee increase is necessary to ensure the program has a six month fund balance. The program needs to maintain a fund balance equal to six months of expenditures in order to meet its commitment to ensure the quality and safety of electrical work performed by contractors.

Reasons Supporting Proposal: See Purpose statement above.

Statutory Authority for Adoption: Chapter 19.28 RCW and chapter 50, Laws of 2011 (2ESHB 1087).

Statute Being Implemented: Chapter 19.28 RCW and chapter 50, Laws of 2011 (2ESHB 1087).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: L&I, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Jose Rodriguez, Tumwater, Washington, (360) 902-6348.

No small business economic impact statement has been prepared under chapter 19.85 RCW. L&I is exempt from preparing a small business economic impact statement under RCW 19.85.025 referencing RCW 34.05.310 (4)(f), since the purpose of this rule making is to set and adjust fees authorized by the passed statute.

A cost-benefit analysis is not required under RCW 34.05.328. L&I is exempt from preparing a cost-benefit analysis under RCW 34.05.328 (5)(b)(vi) because rule making is setting and adjusting fees authorized by the passed statute.

March 6, 2012
Judy Schurke
Director

AMENDATORY SECTION (Amending WSR 10-18-025, filed 8/24/10, effective 10/1/10)

WAC 296-46B-906 Inspection fees. To calculate inspection fees, the amperage is based on the conductor ampacity or the overcurrent device rating. The total fee must not be less than the number of progress inspection (one-half hour) units times the progress inspection fee rate from subsection (8) of this section, PROGRESS INSPECTIONS.

The amount of the fee due is calculated based on the fee effective at the date of a department assessed fee (e.g., plan review or fee due) or when the electrical permit is purchased.

(1) **Residential.**

(a) **Single- and two-family residential (New Construction).**

Notes:

(1) Square footage is the area included within the surrounding exterior walls of a building exclusive of any interior courts. (This includes any floor area in an attached garage, basement, or unfinished living space.)
(2) "Inspected with the service" means that a separate service inspection fee is included on the same electrical work permit.
(3) "Inspected at the same time" means all wiring is to be ready for inspection during the initial inspection trip.
(4) An "outbuilding" is a structure that serves a direct accessory function to the residence, such as a pump house or storage building. Outbuilding does not include buildings used for commercial type occupancies or additional dwelling occupancies.

(i) First 1300 sq. ft.	$((~~86.60~~)) 90.30
Each additional 500 sq. ft. or portion of	$((~~27.70~~)) 28.90
(ii) Each outbuilding or detached garage - inspected at the same time as a dwelling unit on the property	$((~~36.10~~)) 37.60
(iii) Each outbuilding or detached garage - inspected separately	$((~~57.10~~)) 59.50
(iv) Each swimming pool - inspected with the service	$((~~57.10~~)) 59.50
(v) Each swimming pool - inspected separately	$((~~86.60~~)) 90.30
(vi) Each hot tub, spa, or sauna - inspected with the service	$((~~36.10~~)) 37.60
(vii) Each hot tub, spa, or sauna - inspected separately	$((~~57.10~~)) 59.50
(viii) Each septic pumping system - inspected with the service	$((~~36.10~~)) 37.60
(ix) Each septic pumping system - inspected separately	$((~~57.10~~)) 59.50

(b) **Multifamily residential and miscellaneous residential structures, services and feeders (New Construction).**

Each service and/or feeder

Ampacity	Service/Feeder	Additional Feeder
0 to 200	$((~~93.40~~)) 97.40	$((~~27.70~~)) 28.90
201 to 400	$((~~116.10~~)) 121.10	$((~~57.10~~)) 59.50
401 to 600	$((~~159.50~~)) 166.40	$((~~79.40~~)) 82.80
601 to 800	$((~~204.70~~)) 213.50	$((~~109.00~~)) 113.70
801 and over	$((~~291.90~~)) 304.50	$((~~218.90~~)) 228.40

(c) **Single or multifamily altered services or feeders including circuits.**

(i) Each altered service and/or altered feeder

Ampacity	Service/Feeder
0 to 200	$((~~79.40~~)) 82.80
201 to 600	$((~~116.10~~)) 121.10
601 and over	$((~~175.10~~)) 182.60

(ii) Maintenance or repair of a meter or mast (no alterations to the service or feeder)	$((~~43.00~~)) 44.80

(d) **Single or multifamily residential circuits only (no service inspection).**

Note:

Altered or added circuit fees are calculated per panelboard. Total cost of the alterations in an individual panel should not exceed the cost of a complete altered service or feeder of the same rating, as shown in subsection (1) RESIDENTIAL (c) (table) of this section.

(i) 1 to 4 circuits (see note above)	$((~~57.10~~)) 59.50
(ii) Each additional circuit (see note above)	$((~~6.20~~)) 6.40

(e) **Mobile homes, modular homes, mobile home parks, and RV parks.**

(i) Mobile home or modular home service or feeder only	$((~~57.10~~)) 59.50
(ii) Mobile home service and feeder	$((~~93.40~~)) 97.40

(f) **Mobile home park sites and RV park sites.**

Note:

For master service installations, see subsection (2) COMMERCIAL/INDUSTRIAL of this section.

(i) First site service or site feeder	$((~~57.10~~)) 59.50
(ii) Each additional site service; or additional site feeder inspected at the same time as the first service or feeder	$((~~36.10~~)) 37.60

(2) **Commercial/industrial.**

(a) **New service or feeder, and additional new feeders inspected at the same time (includes circuits).**

Note:

For large COMMERCIAL/INDUSTRIAL projects that include multiple feeders, "inspected at the same time" can be interpreted to include additional inspection trips for a single project. The additional inspections must be for electrical work specified on the permit at the time of purchase. The permit fee for such projects must be calculated using this section. However, the total fee must not be less than the number of progress inspection (one-half hour) units times the progress inspection fee rate from subsection (8) PROGRESS INSPECTIONS of this section.

Ampacity	Service/Feeder	Additional Feeder
0 to 100	$((~~93.40~~)) 97.40	$((~~57.10~~)) 59.50
101 to 200	$((~~113.70~~)) 118.60	$((~~72.70~~)) 75.80
201 to 400	$((~~218.90~~)) 228.40	$((~~86.60~~)) 90.30
401 to 600	$((~~255.20~~)) 266.20	$((~~101.90~~)) 106.30
601 to 800	$((~~330.00~~)) 344.30	$((~~138.80~~)) 144.80
801 to 1000	$((~~402.90~~)) 420.30	$((~~168.00~~)) 175.20
1001 and over	$((~~439.50~~)) 458.50	$((~~234.40~~)) 244.50

(b) **Altered services/feeders (no circuits).**

(i) Service/feeder

Ampacity	Service/Feeder
0 to 200	$((~~93.40~~)) 97.40
201 to 600	$((~~218.90~~)) 228.40
601 to 1000	$((~~330.00~~)) 344.30
1001 and over	$((~~366.50~~)) 382.40

(ii) Maintenance or repair of a meter or mast (no alterations to the service or feeder) $((~~79.40~~)) 82.80

(c) **Circuits only.**

Note:

Altered/added circuit fees are calculated per panelboard. Total cost of the alterations in a panel (or panels) should not exceed the cost of a new feeder (or feeders) of the same rating, as shown in subsection (2) COMMERCIAL/INDUSTRIAL (2)(a)(table) above.

(i) First 5 circuits per branch circuit panel $((~~72.70~~)) 75.80

(ii) Each additional circuit per branch circuit panel $((~~6.20~~)) 6.40

(d) **Over 600 volts surcharge per permit.** $((~~72.70~~)) 75.80

(3) **Temporary service(s).**

Notes:

(1) See WAC 296-46B-590 for information about temporary installations.

(2) Temporary stage or concert inspections requested outside of normal business hours will be subject to the portal-to-portal hourly fees in subsection (11) OTHER INSPECTIONS. The fee for such after hours inspections shall be the greater of the fee from this subsection or the portal-to-portal fee.

Temporary services, temporary stage or concert productions.

Ampacity	Service/Feeder	Additional Feeder
0 to 60	$((~~50.00~~)) 52.10	$((~~25.60~~)) 26.70
61 to 100	$((~~57.10~~)) 59.50	$((~~27.70~~)) 28.90
101 to 200	$((~~72.70~~)) 75.80	$((~~36.10~~)) 37.60
201 to 400	$((~~86.60~~)) 90.30	$((~~43.10~~)) 44.90
401 to 600	$((~~116.10~~)) 121.10	$((~~57.10~~)) 59.50
601 and over	$((~~131.70~~)) 137.40	$((~~65.60~~)) 68.40

(4) **Irrigation machines, pumps, and equipment.**

Irrigation machines.

(a) Each tower - when inspected at the same time as a service and feeder from (2) COMMERCIAL/INDUSTRIAL $((~~6.20~~)) 6.40

(b) Towers - when not inspected at the same time as a service and feeder - 1 to 6 towers $((~~86.60~~)) 90.30

(c) Each additional tower $((~~6.20~~)) 6.40

(5) **Miscellaneous - commercial/industrial and residential.**

(a) **A Class 2 low-voltage thermostat** and its associated cable controlling a single piece of utilization equipment or a single furnace and air conditioner combination.

(i) First thermostat $((~~43.10~~)) 44.90

(ii) Each additional thermostat inspected at the same time as the first $((~~13.40~~)) 13.90

(b) **Class 2 or 3 low-voltage systems and telecommunications systems.** Includes all telecommunications installations, fire alarm, nurse call, energy management control systems, industrial and automation control systems, lighting control systems, and similar Class 2 or 3 low-energy circuits and equipment not included in WAC 296-46B-908 for Class B work.

(i) First 2500 sq. ft. or less $((~~50.00~~)) 52.10

(ii) Each additional 2500 sq. ft. or portion thereof $((~~13.40~~)) 13.90

(c) **Signs and outline lighting.**

(i) First sign (no service included) $((~~43.10~~)) 44.90

(ii) Each additional sign inspected at the same time on the same building or structure $((~~20.40~~)) 21.20

(d) **Berth at a marina or dock.**

Note:

Five berths or more shall be permitted to have the inspection fees based on appropriate service and feeder fees from section (2) COMMERCIAL/INDUSTRIAL above.

(i) Berth at a marina or dock $((~~57.10~~)) 59.50

(ii) Each additional berth inspected at the same time $((~~36.10~~)) 37.60

(e) **Yard pole, pedestal, or other meter loops only.**

(i) Yard pole, pedestal, or other meter loops only $((~~57.10~~)) 59.50

(ii) Meters installed remote from the service equipment and inspected at the same time as a service, temporary service or other installations $((~~13.40~~)) 13.90

(f) **Emergency inspections requested outside of normal working hours.**

Regular fee plus surcharge of: $((~~109.00~~)) 113.70

(g) **Generators.**

Note:

Permanently installed generators: Refer to the appropriate residential or commercial new/altered service or feeder section.

Portable generators: Permanently installed transfer equipment for portable generators $((~~79.40~~)) 82.80

(h) **Electrical - annual permit fee.**

Note:

See WAC 296-46B-901(14).

For commercial/industrial location employing full-time electrical maintenance staff or having a yearly maintenance contract with a licensed electrical contractor. Note, all yearly maintenance contracts must detail the number of contractor electricians necessary to complete the work required under the contract. This number will be used as a basis for calculating the appropriate fee. Each inspection is based on a 2-hour maximum.

	Inspections	Fee
1 to 3 plant electricians	12	$((~~2,098.70~~)) 2,189.70
4 to 6 plant electricians	24	$((~~4,199.60~~)) 4,381.80
7 to 12 plant electricians	36	$((~~6,299.00~~)) 6,572.30
13 to 25 plant electricians	52	$((~~8,399.90~~)) 8,764.40
More than 25 plant electricians	52	$((~~10,500.80~~)) 10,956.50

(i) **Telecommunications - annual permit fee.**

Notes:

(1) See WAC 296-46B-901(13).

(2) Annual inspection time required may be estimated by the purchaser at the rate for "OTHER INSPECTIONS" in this section, charged portal-to-portal per hour.

For commercial/industrial location employing full-time telecommunications maintenance staff or having a yearly maintenance contract with a licensed electrical/telecommunications contractor.

2-hour minimum	$((~~173.50~~)) 181.00
Each additional hour, or portion thereof, of portal-to-portal inspection time	$((~~86.60~~)) 90.30

(j) **Permit requiring ditch cover inspection only.**

Each 1/2 hour, or portion thereof	$((~~43.10~~)) 44.90
(k) **Cover inspection for elevator/conveyance installation. This item is only available to a licensed/registered elevator contractor.**	$((~~72.70~~)) 75.80

(6) **Carnival inspections.**

(a) **First carnival field inspection each calendar year.**

(i) Each ride and generator truck	$((~~20.40~~)) 21.20
(ii) Each remote distribution equipment, concession, or gaming show	$((~~6.20~~)) 6.40
(iii) If the calculated fee for first carnival field inspection above is less than $100.50, the minimum inspection fee shall be:	$((~~109.00~~)) 113.70

(b) **Subsequent carnival inspections.**

(i) First ten rides, concessions, generators, remote distribution equipment, or gaming show	$((~~109.00~~)) 113.70
(ii) Each additional ride, concession, generator, remote distribution equipment, or gaming show	$((~~6.20~~)) 6.40

(c) **Concession(s) or ride(s) not part of a carnival.**

(i) First field inspection each year of a single concession or ride, not part of a carnival	$((~~86.60~~)) 90.30
(ii) Subsequent inspection of a single concession or ride, not part of a carnival	$((~~57.10~~)) 59.50

(7) **Trip fees.**

(a) Requests by property owners to inspect existing installations. (This fee includes a maximum of one hour of inspection time. All inspection time exceeding one hour will be charged at the rate for progressive inspections.)	$((~~86.60~~)) 90.30
(b) Submitter notifies the department that work is ready for inspection when it is not ready.	$((~~43.10~~)) 44.90
(c) Additional inspection required because submitter has provided the wrong address or incomplete, improper or illegible directions for the site of the inspection.	$((~~43.10~~)) 44.90
(d) More than one additional inspection required to inspect corrections; or for repeated neglect, carelessness, or improperly installed electrical work.	$((~~43.10~~)) 44.90
(e) Each trip necessary to remove a noncompliance notice.	$((~~43.10~~)) 44.90
(f) Corrections that have not been made in the prescribed time, unless an exception has been requested and granted.	$((~~43.10~~)) 44.90
(g) Installations that are covered or concealed before inspection.	$((~~43.10~~)) 44.90

(8) **Progress inspections.**

Note:

The fees calculated in subsections (1) through (6) of this section will apply to all electrical work. This section will be applied to a permit where the permit holder has requested additional inspections beyond the number supported by the permit fee calculated at the rate in subsections (1) through (6) of this section.

On partial or progress inspections, each 1/2 hour.	$((~~43.10~~)) 44.90

(9) **Plan review.**

Fee is thirty-five percent of the electrical work permit fee as determined by WAC 296-46B-906, plus a plan review submission and shipping/handling fee of:	$((~~72.70~~)) 75.80
(a) Supplemental submissions of plans per hour or fraction of an hour of review time.	$((~~86.60~~)) 90.30
(b) Plan review shipping and handling fee.	$((~~20.40~~)) 21.20

(10) **Out-of-state inspections.**

(a) Permit fees will be charged according to the fees listed in this section.

(b) Travel expenses:

All travel expenses and per diem for out-of-state inspections are billed following completion of each inspection(s). These expenses can include, but are not limited to: Inspector's travel time, travel cost and per diem at the state rate. Travel time is hourly based on the rate in subsection (11) of this section.

(11) **Other inspections.**

Inspections not covered by above inspection fees must be charged portal-to-portal per hour:	$((~~86.60~~)) 90.30

(12) **Variance request processing fee.**

Variance request processing fee. This fee is nonrefundable once the transaction has been validated.	$((~~86.60~~)) 90.30

(13) **Marking of industrial utilization equipment.**

(a) Standard(s) letter review (per hour of review time).	$((~~86.60~~)) 90.30
(b) Equipment marking - charged portal-to-portal per hour:	$((~~86.60~~)) 90.30

(c) All travel expenses and per diem for in/out-of-state review and/or equipment marking are billed following completion of each inspection(s). These expenses can include, but are not limited to: Inspector's travel time, travel cost and per diem at the state rate. Travel time is hourly based on the rate in (b) of this subsection.

(14) **Class B basic electrical work labels.**	
(a) Block of twenty Class B basic electrical work labels (not refundable).	$((~~237.70~~)) 248.00
(b) Reinspection of Class B basic electrical work to assure that corrections have been made (per 1/2 hour timed from leaving the previous inspection until the reinspection is completed). See WAC 296-46B-908(5).	$((~~43.10~~)) 44.90
(c) Reinspection of Class B basic electrical work because of a failed inspection of another Class B label (per 1/2 hour from previous inspection until the reinspection is completed). See WAC 296-46B-908(5).	$((~~43.10~~)) 44.90
(15) **Provisional electrical work permit labels.**	
Block of twenty provisional electrical work permit labels.	$((~~237.70~~)) 248.00

AMENDATORY SECTION (Amending WSR 10-18-025, filed 8/24/10, effective 10/1/10)

WAC 296-46B-909 Electrical/telecommunications contractor's license, administrator certificate and examination, master electrician certificate and examination, electrician certificate and examination, copy, and miscellaneous fees.

Notes: (1) The department will deny renewal of a license, certificate, or permit if an individual owes money as a result of an outstanding final judgment(s) to the department or is in revoked status. The department will deny application of a license, certificate, or permit if an individual is in suspended status or owes money as a result of an outstanding final judgment(s) to the electrical program.

(2) Certificates may be prorated for shorter renewal periods in one-year increments. Each year or part of a year will be calculated to be one year.

(3) The amount of the fee due is calculated based on the fee effective at the date payment is made.

(1) **General or specialty contractor's license per twenty-four month period. (Nonrefundable after license has been issued.)**	
(a) **Initial application or renewal made in person, by mail, or by fax**	$((~~255.20~~)) 266.20
(b) **Renewal fully completed using the on-line web process**	$230.20
(c) **Reinstatement of a general or specialty contractor's license after a suspension**	$((~~51.70~~)) 53.90
(2) **Master electrician/administrator/electrician/trainee certificate.**	
(a) **Examination application (nonrefundable)**	
Administrator certificate examination application. (Required only for department administered examinations.) (Not required when testing with the department's contractor.)	$((~~32.00~~)) 33.30
(b) **Examination fees (nonrefundable)**	

Note:
Normal examination administration is performed by a state authorized contractor. The fees for such examinations are set by contract with the department. For written examinations administered by the department, use the following fee schedule.

(i) Master electrician or administrator first-time examination fee (when administered by the department)	$((~~77.10~~)) 80.40
(ii) Master electrician or administrator retest examination fee (when administered by the department)	$((~~90.30~~)) 94.20
(iii) Journeyman or specialty electrician examination fee (first test or retest when administered by the department)	$((~~58.00~~)) 60.50
(iv) Certification examination review fee	$((~~119.50~~)) 124.60
(c) **Original certificates (nonrefundable after certificate has been issued)**	
(i) Electrical administrator original certificate (except **09** telecommunication)	$((~~115.40~~)) 120.40
(ii) Telecommunications administrator original certificate (for **09** telecommunications)	$((~~76.80~~)) 80.10
(iii) Master electrician exam application (includes original certificate and application processing fee) **($((~~32.00~~)) 33.30 is nonrefundable after application is submitted)**	$((~~147.60~~)) 154.00
(iv) Journeyman or specialty electrician application (includes original certificate and application processing fee) **($((~~32.00~~)) 33.30 is nonrefundable after application is submitted)**	$((~~82.80~~)) 86.30
(v) Training certificate	
(A) Initial application made in person, by mail, or by fax	$((~~40.60~~)) 42.30
(B) Initial application fully completed on-line using the on-line web process	$36.40
(C) 0% supervision modified training certificate. Includes trainee update of hours (i.e., submission of affidavit of experience) **($((~~49.10~~)) 51.20 is nonrefundable after application is submitted)**	$((~~73.80~~)) 77.00
(D) 75% supervision modified training certificate.	$((~~49.10~~)) 51.20
(E) Unsupervised training certificate as allowed by RCW 19.28.161 (4)(b).	$((~~24.40~~)) 25.40
(d) **Certificate renewal (nonrefundable)**	
(i) Master electrician or administrator certificate renewal	
(A) Renewal made in person, by mail, or by fax	$((~~145.90~~)) 152.20
(B) Renewal fully completed using the on-line web process	$132.20
(ii) Telecommunications **(09)** administrator certificate renewal	
(A) Renewal made in person, by mail, or by fax	$((~~97.20~~)) 101.40
(B) Renewal fully completed using the on-line web process	$87.50
(iii) Late renewal of master electrician or administrator certificate	
(A) Renewal made in person, by mail, or by fax	$((~~291.80~~)) 304.40
(B) Renewal fully completed using the on-line web process	$264.50
(iv) Late renewal of telecommunications **(09)** administrator certificate	
(A) Renewal made in person, by mail, or by fax	$((~~194.50~~)) 202.90
(B) Renewal fully completed using the on-line web process	$175.00
(v) Journeyman or specialty electrician certificate renewal	
(A) Renewal made in person, by mail, or by fax	$((~~76.80~~)) 80.10
(B) Renewal fully completed using the on-line web process	$69.70
(vi) Late renewal of journeyman or specialty electrician certificate	
(A) Renewal made in person, by mail, or by fax	$((~~153.70~~)) 160.30
(B) Renewal fully completed using the on-line web process	$139.50

(vii) Trainee update of hours outside of renewal period (i.e., submission of affidavit of experience outside of the timeline in WAC 296-46B-965 (7)(d))	$((~~49.10~~)) 51.20
(viii) Trainee certificate renewal	
(A) Renewal made in person, by mail, or by fax	$((~~49.10~~)) 51.20
(B) Renewal fully completed using the on-line web process when the affidavit of experience is submitted per WAC 296-46B-965 (7)(d)	$44.70
(ix) Late trainee certificate renewal	
(A) Renewal made in person, by mail, or by fax	$((~~68.90~~)) 71.80
(B) Renewal fully completed using the on-line web process	$62.50
(e) **Certificate - reinstatement (nonrefundable)**	
(i) Reinstatement of a suspended master electrician or administrator's certificate (in addition to normal renewal fee)	$((~~51.70~~)) 53.90
(ii) Reinstatement of suspended journeyman, or specialty electrician certificate (in addition to normal renewal fee)	$((~~24.40~~)) 25.40
(f) **Assignment/unassignment of master electrician/administrator designation (nonrefundable)**	$((~~38.30~~)) 39.90
(3) **Certificate/license.**	
(a) Replacement for lost or damaged certificate/license. (Nonrefundable.)	$((~~16.80~~)) 17.50
(b) Optional display quality General Master Electrician certificate.	$((~~27.30~~)) 28.40
(4) **Continuing education courses or instructors. (Nonrefundable.)**	
(a) If the course or instructor review is performed by the electrical board or the department	
The course or instructor review	$((~~49.20~~)) 51.30
(b) If the course or instructor review is contracted out by the electrical board or the department	
(i) Continuing education course or instructor submittal and approval (per course or instructor)	As set in contract
(ii) Applicant's request for review, by the chief electrical inspector, of the contractor's denial	$((~~119.80~~)) 124.90
(5) **Copy fees. (Nonrefundable.)**	
(a) **Certified copy of each document (maximum charge per file):**	$((~~54.40~~)) 56.70
(i) First page:	$((~~24.40~~)) 25.40
(ii) Each additional page:	$2.10
(b) Replacement RCW/WAC printed document:	$((~~5.40~~)) 5.60
(6) **Training school program review fees. Initial training school program review fee. (Nonrefundable.)**	
(a) Initial training school program review fee submitted for approval. Valid for three years or until significant changes in program content or course length are implemented (see WAC 296-46B-971(4)).	$((~~565.40~~)) 589.90
(b) Renewal of training school program review fee submitted for renewal. Valid for 3 years or until significant changes in program content or course length are implemented (see WAC 296-46B-971(4)).	$((~~282.70~~)) 294.90

AMENDATORY SECTION (Amending WSR 10-18-025, filed 8/24/10, effective 10/1/10)

WAC 296-46B-911 Electrical testing laboratory and engineer accreditation fees. The amount of the fee due is calculated based on the fee effective at the date payment is made.

Electrical testing laboratory	
Initial filing fee: (Nonrefundable)	$((~~537.50~~)) 560.80
Initial accreditation fee:	
1 product category	$((~~268.70~~)) 280.30
Each additional category for the next 19 categories	$((~~107.50~~)) 112.10 each
Maximum for 20 categories or more	$((~~2,311.30~~)) 2,411.60
Renewal fee: (Nonrefundable)	50% of initial filing fee
Renewal of existing accreditations	
Each additional category for the next 19 categories	$((~~107.50~~)) 112.10 each
Maximum for 20 categories or more	$((~~2,311.30~~)) 2,411.60
Engineer for evaluating industrial utilization equipment	
Initial filing fee: (Nonrefundable)	$((~~537.50~~)) 560.80
Renewal fee: (Nonrefundable)	50% of initial filing fee

WSR 12-06-073
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
[Filed March 6, 2012, 2:22 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 12-03-048.

Title of Rule and Other Identifying Information: WAC 388-02-0010 What definitions apply to this chapter? and 388-02-0220 What rules and laws must an ALJ and review judge apply when conducting a hearing or making a decision?

Hearing Location(s): Office Building 2, Lookout Room, DSHS Headquarters, 1115 Washington, Olympia, WA 98504 (public parking at 11th and Jefferson. A map is available at http://www1.dshs.wa.gov/msa/rpau/RPAU-OB-2directions.html or by calling (360) 664-6094), on April 10, 2012, at 10:00 a.m.

Date of Intended Adoption: Not earlier than April 11, 2012.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504-5850, delivery 1115 Washington Street S.E., Olympia, WA 98504, e-mail DSHSRPAURulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5 p.m. on April 10, 2012.

Assistance for Persons with Disabilities: Contact Jennisha Johnson, DSHS rules consultant, by March 21, 2012,

TTY (360) 664-6178 or (360) 664-6094 or by e-mail at jennisha.johnson@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to make these rules more consistent with case law, other Washington regulations, and Washington statutes that refer to the date of the department's action, conduct, or decision rather than to the date of its notice. It is also necessary to manage budget shortfalls, which will require swift programmatic changes and associated amendments to program rules. The proposed changes to chapter 388-02 WAC will enable the department to fulfill its due process obligation to notify parties of upcoming program changes before the associated amended program rules go into effect and will require application of those amended rules to any disputes about the department's action.

Reasons Supporting Proposal: The current rule states that administrative law judges and review judges must apply the program rules in effect on the date the department sent notice of its intended action to the parties. This is not consistent with case law stating that the date of agency conduct or action determines which law applies. It is also not consistent with the department's due process obligation to send parties advance notice of department action prior to the effective date of the action and the amended rules on which the action is based. The proposed amendments resolve these inconsistencies. The proposed amendments also enable application of program rules amended due to budget shortfalls, which may become effective after the date of the department's notice but before (or on) the date of the department's action.

Statutory Authority for Adoption: RCW 34.05.020.

Statute Being Implemented: RCW 34.05.020.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of social and health services, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Dia Tornatore, P.O. Box 45803, Olympia, WA 98504-5803, (360) 664-6061.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These are procedural rules and are exempt under RCW 19.85.025(3) and 34.005.-310 [34.05.310] (4)(g)(i).

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rules are not "significant legislative rule" under RCW 34.05.328 (5)(c)(iii). Under RCW 34.05.-328 (5)(a)(i), a cost-benefit analysis is only required for significant legislative rules.

March 2, 2012
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-04-074, filed 1/31/11, effective 3/3/11)

WAC 388-02-0010 What definitions apply to this chapter? The following definitions apply to this chapter:

"Administrative law judge (ALJ)" means an impartial decision-maker who is an attorney and presides at an administrative hearing. The office of administrative hearings (OAH), which is a state agency, employs the ALJs. ALJs are not department employees or department representatives.

"BOA" means the board of appeals.

"Business days" means all days except Saturdays, Sundays and legal holidays.

"Calendar days" means all days including Saturdays, Sundays and legal holidays.

"Date of the department action" means the date when the department's decision is effective.

"Deliver" means giving a document to someone in person.

"Department" means the department of social and health services.

"Documents" means papers, letters, writings, or other printed or written items.

"DSHS" means the department of social and health services.

"DSHS or department representative" means an employee of the department, a department contractor, or an assistant attorney general authorized to represent the department in an administrative hearing. Department representatives include, but are not limited to, claims officers and administrative hearing coordinators.

"Final order" means an order that is the final department decision.

"Hearing" means a proceeding before an ALJ or review judge that gives a party an opportunity to be heard in disputes about department programs. For purposes of this chapter, hearings include administrative hearings, adjudicative proceedings, and any other similar term referenced under chapter 34.05 RCW, the Administrative Procedure Act, Title 388 of the Washington Administrative Code (WAC), chapter 10-08 WAC, or other law.

"Initial order" is a hearing decision made by an ALJ that may be reviewed by a BOA review judge at either party's request.

"Judicial review" means a superior court's review of a final order.

"Mail" means placing a document in the mail with the proper postage.

"OAH" means the office of administrative hearings, a separate state agency from the department.

"Party" means:

(1) The department or DSHS; or

(2) A person or entity:

(a) Named in a department action;

(b) To whom a department action is directed; or

(c) Allowed to participate in a hearing to protect an interest as authorized by law or rule.

"Prehearing conference" means a proceeding scheduled and conducted by an ALJ or review judge in preparation for a hearing.

"Prehearing meeting" means an informal voluntary meeting that may be held before any prehearing conference or hearing.

"Program" means a department organizational unit and the services that it provides, including services provided by department staff and through contracts with providers. Organizational units include, but are not limited to, administrations and divisions.

"Record" means the official documentation of the hearing process. The record includes recordings or transcripts, admitted exhibits, decisions, briefs, notices, orders, and other filed documents.

"Review" means a review judge evaluating initial orders entered by an ALJ and making the final agency decision as provided by RCW 34.05.464, or issuing final orders.

"Review judge" means a decision-maker with expertise in department rules who is an attorney and serves as the reviewing officer under RCW 34.05.464. In some cases, review judges conduct hearings and enter final orders. In other cases, they review initial orders and may make changes to correct any errors in an ALJ's initial order. After reviewing initial orders or conducting hearings, review judges enter final orders. Review judges are employed by the department, are located in the board of appeals (BOA), and are not part of the department program involved in the review. See WAC 388-02-0600 for information on the authority of a review judge.

"Rule" means a state regulation. Rules are found in the Washington Administrative Code (WAC).

"Should" means that an action is recommended but not required.

"Stay" means an order temporarily halting the department decision or action.

"You" means any individual or entity that has a right to be involved with the department hearing process, which includes a party or a party's representative. "You" does not include the department or its representative.

AMENDATORY SECTION (Amending WSR 11-04-074, filed 1/31/11, effective 3/3/11)

WAC 388-02-0220 What rules and laws must an ALJ and review judge apply when conducting a hearing or making a decision? (1) ALJs and review judges must first apply the department rules adopted in the Washington Administrative Code.

(2) If no department rule applies, the ALJ or review judge must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, and court decisions.

(3) When applying program rules regarding the substantive rights and responsibilities of the parties (such as eligibility for services, benefits, or a license), the ALJ and review judge must apply the program rules ((~~that were~~)) in effect on the date of the department ((~~notice was sent~~)) action, unless otherwise required by other rule or law. If the department amends ((~~the~~)) its notice of the action, the ALJ and review judge must apply the rules ((~~that were~~)) in effect on the date the ((~~initial notice was sent~~)) action was taken, unless otherwise required by other rule or law.

(4) When applying program rules regarding the procedural rights and responsibilities of the parties, the ALJ and review judge must apply the rules that are in effect on the date the procedure is followed.

(5) Program rules determine the amount of time the department has to process your application for services, benefits or a license.

(6) The ALJ and review judge must apply the rules in this chapter beginning on the date each rule is effective.

(7) If you have a dispute with the department concerning the working connections child care (WCCC) program, the ALJ and review judge must apply the hearing rules in this chapter and not the hearing rules in chapter 170-03 WAC. The rules in this chapter apply to disputes between you and the department of social and health services.

WSR 12-06-074
PROPOSED RULES
DEPARTMENT OF REVENUE

[Filed March 6, 2012, 3:34 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 12-01-096.

Title of Rule and Other Identifying Information: WAC 458-20-10202 (Rule 10202) Brief adjudicative proceedings for matters related to reseller permits.

Hearing Location(s): Capital Plaza Building, 4th Floor Conference Room Large (L&P), 1025 Union Avenue S.E., Olympia, WA 98504, on April 12, 2012, at 10:00 a.m.

Date of Intended Adoption: April 18, 2012.

Submit Written Comments to: Gayle Carlson, e-mail GayleC@dor.wa.gov, P.O. Box 47453, Olympia, WA 98504-7453, by April 12, 2012.

Assistance for Persons with Disabilities: Contact Mary Carol LaPalm, (360) 725-7499, or Renee Cosare, (360) 725-7514, no later than ten days before the hearing date. For hearing impaired please contact us via the Washington relay operator at (800) 833-6384.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department of revenue (department) proposes to revise Rule 10202 to adopt the brief adjudicative proceedings for the following:

- A determination of whether a reseller permit should be revoked using the criteria per RCW 82.32.780 and WAC 458-20-102 (Rule 102) Reseller permits; and
- On the administrative appeal of an initial order revoking a taxpayer's reseller permit, a determination as to whether the department's order revoking the permit was correctly based on the criteria as set forth in RCW 82.32.780 and Rule 102.

Copies of draft rules are available for viewing and printing on our web site at Rules Agenda.

Reasons Supporting Proposal: To explain the process by which a taxpayer may appeal a department action to revoke a reseller permit.

Statutory Authority for Adoption: RCW 82.32.300 and 82.01.060(2).

Statute Being Implemented: RCW 82.32.780 and 82.32.783.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of revenue, governmental.

Name of Agency Personnel Responsible for Drafting: Gayle Carlson, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1576; Implementation: Alan R. Lynn, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1599; and Enforcement: Russ Brubaker, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1505.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This rule does not impose any new performance requirement or administrative burden on any small business not already required by statute.

A cost-benefit analysis is not required under RCW 34.05.328. This is not a significant legislative rule as defined in RCW 34.05.328.

March 6, 2012
Alan R. Lynn
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-14-080, filed 7/1/10, effective 8/1/10)

WAC 458-20-10202 Brief adjudicative proceedings for matters related to reseller permits. (1) **Introduction.** The department of revenue (department) conducts adjudicative proceedings pursuant to chapter 34.05 RCW, the Administrative Procedure Act (APA). The department adopts in this section the brief adjudicative procedures as provided in RCW 34.05.482 through 34.05.494 for the administration of brief adjudicative proceedings for the following matters related to reseller permits:

(a) A determination of whether an applicant for a reseller permit meets the criteria for a reseller permit per WAC 458-20-10201; ((~~and~~))

(b) On the administrative appeal of an initial order denying the taxpayer's application for a reseller permit, a determination as to whether the department's order denying the application was correctly based on the criteria for approving reseller permits as set forth in WAC 458-20-10201;

(c) A determination of whether a reseller permit should be revoked using the criteria per RCW 82.32.780 and WAC 458-20-102; and

(d) On the administrative appeal of an initial order revoking the taxpayer's reseller permit, a determination as to whether the department's order revoking the permit was correctly based on the criteria as set forth in RCW 82.32.780 and WAC 458-20-102.

This section explains the procedure and process pertaining to the adopted brief adjudicative proceedings.

(2) **Record in brief adjudicative proceedings.**

(a) The record with respect to a taxpayer's appeal per RCW 34.05.482 through 34.05.485 of the department's denial of an application for a reseller permit will consist of:

((~~(a)~~)) (i) The taxpayer's application for the reseller permit, the taxpayer's notice of appeal, the taxpayer's written response, if any, to the reasons set forth in the department's notice of denial of a reseller permit, ((~~and~~)) all records relied upon by the department or submitted by the taxpayer; and

((~~(b)~~)) (ii) All correspondence between the taxpayer requesting the reseller permit and the department regarding the application for the reseller permit.

(b) The record with respect to a taxpayer's appeal per RCW 34.05.482 through 34.05.485 of the department's initial order revoking a reseller permit will consist of the department's notice of intent to revoke the reseller permit, the taxpayer's written response to the department's notice of intent to revoke, the taxpayer's notice of appeal, and all records relied upon by the department, or submitted by the taxpayer.

(3) **Conduct of brief adjudicative proceedings.**

(a) If the department denies an application for a reseller permit, it will notify the taxpayer of the denial in writing, stating the reasons for the denial. To initiate an appeal of the denial of the reseller permit application, the taxpayer must file a written appeal no later than twenty-one days after service of the department's written notice that the taxpayer's application has been denied.

((~~(a)~~)) (b) If the department proposes to revoke a reseller permit, it will notify the taxpayer of the proposed revocation in writing, stating the reasons for the proposed revocation. To contest the proposed revocation of the reseller permit, the taxpayer must file a written response no later than twenty-one days after service of the department's written notice of the proposed revocation of the reseller permit.

(c) A Reseller Permit Appeal Petition form ((~~notice of appeal of the denial of a reseller permit application (Reseller Permit Appeal Petition)~~)), or form for a response to the proposed revocation of a reseller permit is available at http://dor.wa.gov or by calling 1-800-647-7706. The completed form should be mailed or faxed to the department at:

Department of Revenue
Taxpayer Account Administration
P.O. Box 47476
Olympia, WA 98504-7476
Fax: 360-705-6733

((~~(b)~~)) (d) A presiding officer, who will be either the assistant director of the taxpayer account administration division or such other person as designated by the director of the department (director), will conduct brief adjudicative proceedings. The presiding officer for brief adjudicative proceedings will have agency expertise in the subject matter but will not otherwise have participated in responding to the taxpayer's application for a reseller permit or in the decision to propose revocation of the taxpayer's reseller permit.

((~~(c)~~)) (e) As part of the appeal, the taxpayer or the taxpayer's representative may present written documentation and explain the taxpayer's view of the matter. The presiding officer may request additional documentation from the taxpayer or the department and will designate the date by which the documents must be submitted.

((~~(d)~~)) (f) No witnesses may appear to testify.

((~~(e)~~)) (g) In addition to the record, the presiding officer for brief adjudicative proceedings may employ agency expertise as a basis for decision.

((~~(f)~~)) (h) Within twenty-one days of receipt of the taxpayer's appeal of the denial of a reseller permit or proposed revocation of the reseller permit, the presiding officer will enter an initial order, including a brief explanation of the decision per RCW 34.05.485. All orders in these brief adjudicative proceedings will be in writing. The initial order will become the department's final order unless an appeal is filed

with the department's appeals division in subsection (4) of this section.

(4) **Review of initial orders from brief adjudicative proceeding.** A taxpayer ((~~that had its application for a reseller permit denied in an initial order issued per subsection (3) of this section~~)) may request a review by the department of an initial order issued per subsection (3) of this section by filing a petition for review or by making an oral request for review with the department's appeals division within twenty-one days after the service of the initial order on the taxpayer. A form for an appeal of an initial order per subsection (3) of this section ((~~denying the taxpayer's application for a reseller permit~~)) is available at http://dor.wa.gov. A request for review should state the reasons the review is sought. A taxpayer making an oral request for review may at the same time mail a written statement to the address below stating the reasons for the appeal and its view of the matter. The address, telephone number, and fax number of the appeals division are:

Appeals Division, Reseller Permit Appeals
Department of Revenue
P.O. Box 47476
Olympia, WA 98504-7476
Telephone Number: 1-800-647-7706
Fax: 360-705-6733

(a) A reviewing officer, who will be either the assistant director of the appeals division or such other person as designated by the director, will conduct brief adjudicative proceedings and determine whether the department's ((~~denial of the taxpayer's application~~)) initial order issued per subsection (3) of this section was correctly based on the criteria ((~~for approving reseller permits as~~)) set forth in ((~~WAC~~)) RCW 82.32.780, WAC 458-20-102, and 458-20-10201. The reviewing officer will review the record and, if needed, convert the proceeding to a formal adjudicative proceeding.

(b) The agency record need not constitute the exclusive basis for the reviewing officer's decision. The reviewing officer will have the authority of a presiding officer.

(c) The order of the reviewing officer will be in writing and include a brief statement of the reasons for the decision, and it must be entered within twenty days of the petition for review. The order will include a notice that judicial review may be available. The order of the reviewing officer represents the final decision of the department.

(d) A request for administrative review is deemed denied if the department does not issue an order on review within twenty days after the petition for review is filed or orally requested.

(5) **Conversion of a brief adjudicative proceeding to a formal proceeding.** The presiding officer or reviewing officer may convert the brief adjudicative proceeding to a formal proceeding at any time on motion of the taxpayer, the department, or the presiding/reviewing officer's own motion.

(a) The presiding/reviewing officer will convert the proceeding when it is found that the use of the brief adjudicative proceeding violates any provision of law, when the protection of the public interest requires the agency to give notice to and an opportunity to participate to persons other than the parties, and when the issues and interests involved warrant the use of the procedures of RCW 34.05.413 through 34.05.479.

(b) When a proceeding is converted from a brief adjudication to a formal proceeding, the director may become the presiding officer or may designate a replacement presiding officer to conduct the formal proceedings upon notice to the taxpayer and the department.

(c) In the conduct of the formal proceedings, WAC 458-20-10002 will apply to the proceedings.

(6) **Court appeal.** Court appeal from the final order of the department is available pursuant to Part V, chapter 34.05 RCW. However, court appeal may be available only if a review of the initial decision has been requested under subsection (4) of this section and all other administrative remedies have been exhausted. See RCW 34.05.534.

(7) **Computation of time.** In computing any period of time prescribed by this section or by the presiding officer, the day of the act or event after which the designated period is to run is not to be included. The last day of the period is to be included, unless it is a Saturday, Sunday or a legal holiday, in which event the period runs until the next day which is not a Saturday, Sunday or legal holiday. When the period of time prescribed is less than seven days, intermediate Saturdays, Sundays and holidays are excluded in the computation. Service as discussed in subsection (8) of this section is deemed complete upon mailing.

(8) **Service.** All notices and other pleadings or papers filed with the presiding or reviewing officer must be served on the taxpayer, their representatives/agents of record, and the department.

(a) Service is made by one of the following methods:

(i) In person;

(ii) By first-class, registered or certified mail;

(iii) By fax and same-day mailing of copies;

(iv) By commercial parcel delivery company; or

(v) By electronic delivery pursuant to RCW 82.32.135.

(b) Service by mail is regarded as completed upon deposit in the United States mail properly stamped and addressed.

(c) Service by electronic fax is regarded as completed upon the production by the fax machine of confirmation of transmission.

(d) Service by commercial parcel delivery is regarded as completed upon delivery to the parcel delivery company, properly addressed with charges prepaid.

(e) Service by electronic delivery is regarded as completed on the date that the department electronically sends the information to the parties or electronically notifies the parties that the information is available to be accessed by them.

(f) Service to a taxpayer, their representative/agent of record, the department, and presiding officer must be to the address shown on the notice described in subsection (3)(a) of this section.

(g) Service to the reviewing officer must be to the appeals division at the address shown in subsection (4) of this section.

(h) Where proof of service is required, the proofs of service must include:

(i) An acknowledgment of service;

(ii) A certificate, signed by the person who served the document(s), stating the date of service; that the person did serve the document(s) upon all or one or more of the parties of record in the proceeding by delivering a copy in person to (names); and that the service was accomplished by a method of service as provided in this subsection.

(9) **Continuance.** The presiding officer or reviewing officer may grant a request for a continuance by motion of the taxpayer, the department, or on its own motion.

WSR 12-06-076
PROPOSED RULES
OFFICE OF INSURANCE COMMISSIONER
[Insurance Commissioner Matter No. R 2012-01—Filed March 7, 2012, 9:05 a.m.]

Original Notice.

Expedited rule making—Proposed notice was filed as WSR 12-02-089.

Title of Rule and Other Identifying Information: Chapter 284-02 WAC, Insurance commissioner's office.

Hearing Location(s): OIC Tumwater Office, Training Room 120, 5000 Capitol Boulevard, Tumwater, WA, http://www.insurance.wa.gov/about/directions.shtml, on April 12, 2012, at 2:00 p.m.

Date of Intended Adoption: April 16, 2012.

Submit Written Comments to: Kacy Scott, P.O. Box 40258, Olympia, WA 98504-0258, e-mail kacys@oic.wa.gov, fax (360) 586-3109, by April 10, 2012.

Assistance for Persons with Disabilities: Contact Lorrie [Lorie] Villaflores by April 10, 2012, TTY (360) 586-0241 or (360) 725-7087.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This proposed rule is part of the commissioner's annual review of Title 284 WAC.

Reasons Supporting Proposal: The proposed amendments improve the clarity and accuracy of the chapter.

Statutory Authority for Adoption: RCW 48.02.060 and 34.05.220.

Statute Being Implemented: RCW 34.05.220.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Kacy Scott, P.O. Box 40258, Olympia, WA 98504-0258, (360) 725-7041; Implementation and Enforcement: Carol Sureau, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7050.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These rules relate only to the internal operations of the insurance commissioner's office. No small business economic impact statement is required because the rules will impose no costs on business in an industry.

A cost-benefit analysis is not required under RCW 34.05.328. These rules relating to the internal operations of the insurance commissioner's office, are procedural rules as defined by 34.05.328, and therefore do not require a cost-benefit analysis.

March 7, 2012
Mike Kreidler
Insurance Commissioner

Chapter 284-02 WAC

((~~DESCRIPTION OF~~)) INSURANCE COMMISSIONER'S OFFICE—((~~ORGANIZATION OPERATIONS AND OBTAINING INFORMATION~~)) GENERALLY

AMENDATORY SECTION (Amending Matter No. R 2010-09, filed 12/22/10, effective 1/22/11)

WAC 284-02-010 ((~~What are the responsibilities of the insurance commissioner and the office of the insurance commissioner (OIC) staff?~~)) SHIBA. ((~~The insurance commissioner is responsible for regulating the insurance industry and all persons or entities transacting insurance business in this state in the public interest. The position of insurance commissioner was established by the legislature as an independent, elective office in 1907. The insurance laws and the authority of the insurance commissioner are found in Title 48 RCW. The insurance commissioner's powers are set forth in chapter 48.02 RCW.~~

~~(1) **General powers and tasks.**~~

~~(a) To carry out the task of enforcing the insurance code the commissioner:~~

~~(i) May make rules and regulations governing activities under the insurance code (Title 48 RCW);~~

~~(ii) May conduct investigations to determine whether any person has violated any provision of the insurance code, including both informal and formal hearings;~~

~~(iii) May take action (including levying of fines and revocation of authority to transact business in this state) against an insurance company, fraternal benefit society, charitable gift annuity providers, health maintenance organization, health care service contractor, motor vehicle service contract provider, service contract provider, protection product guarantee providers, self-funded multiple employer welfare arrangement, and life settlement provider; and~~

~~(iv) May issue, refuse to issue or renew, place on probation, revoke, or suspend the licenses of insurance producers, title insurance agents, surplus line brokers, adjusters, insurance education providers, reinsurance intermediaries, and life settlement brokers, or may fine any of them for violations of the insurance code.~~

~~(b) All insurers and other companies regulated under the insurance code must meet financial, legal, and other requirements and must be licensed, registered, or certified by the OIC prior to the transaction of insurance in this state.~~

~~(c) The OIC is responsible for collecting a premium-based tax levied against insurers and other companies transacting insurance business in this state. The funds collected from health care companies are deposited into the state's health services account. All other taxes are deposited into the state's general fund.~~

~~(d) Any person engaged in the marketing or sale of insurance in Washington must hold a license issued by the OIC. The OIC oversees the prelicensing education, testing, licensing, continuing education, and renewal of insurance producer, surplus line broker and title insurance agent licenses.~~

~~(e) Public and independent adjusters must be licensed by the OIC. The OIC is responsible for the processing of licenses, background checks, affiliations, testing, renewals, terminations, and certificates for individuals and business entities, both resident and nonresident, who act as independent or public adjusters in Washington.~~

~~(f) The OIC assists persons who have complaints about companies, insurance producers, surplus line brokers and title insurance agents, or other licensees of the OIC. OIC investigators follow up on consumer complaints, look into circumstances of disputes between consumers and licensees, and respond to questions.~~

~~(g) The OIC publishes and distributes consumer guides and fact sheets to help inform consumers about their choices and rights when buying and using insurance.~~

~~(2) **Orders.** The commissioner may issue a cease and desist order based on the general enforcement powers granted by RCW 48.02.080, or may bring an action in court to enjoin violations of the insurance code.~~

~~(3) **SHIBA.**~~)) The OIC offers assistance statewide to consumers regarding health care insurance and health care access through its statewide health insurance benefits advisors (SHIBA) ((~~"HelpLine"~~)) program. Volunteers are trained by OIC employees to provide counseling, education, and other assistance to residents of Washington. Information about SHIBA, including how to become a SHIBA volunteer, can be found on the OIC web site ((~~(~~))www.insurance.wa.gov((~~).~~

~~(4) **Publication of tables for courts and appraisers.** The insurance commissioner publishes tables showing the average expectancy of life and values of annuities and life and term estates for the use of the state courts and appraisers (RCW 48.02.160).~~

~~(5) **Copies of public documents.** Files of completed investigations, complaints against insurers or other persons or entities authorized to transact the business of insurance by the OIC, and copies of completed rate or form filings are generally available for public inspection and copying during business hours (see chapter 284-03 WAC) at the OIC's office in Tumwater, subject to other applicable law. Access by the public to information and records of the insurance commissioner is governed by chapter 284-03 WAC and the Public Records Act (chapter 42.56 RCW). Information on how to request copies of public documents is available on the OIC web site (www.insurance.wa.gov).~~

~~(6) **Web site.** The insurance commissioner maintains a web site at: www.insurance.wa.gov. Current detailed information regarding insurance, persons and entities authorized to transact insurance business in this state, consumer tips, links to Washington's insurance laws and rules, a list of publications available to the public, and other valuable information can be found on the web site.~~

~~(7) **Toll-free consumer hotline.** Members of the OIC staff respond to inquiries of consumers who telephone the agency's toll-free consumer hotline at 1-800-562-6900.~~

~~(8) **Location of offices.** The OIC's headquarters office is located in the insurance building on the state Capitol campus in Olympia. Branch offices are located in Tumwater, Seattle and Spokane. Addresses for the office locations can be found on the OIC web site (www.insurance.wa.gov) or by calling the commissioner's consumer hotline (1-800-562-6900).~~

~~(9) **Antifraud program.** Beginning in 2007, the OIC (in partnership with the Washington state patrol, county prosecutors, and the state attorney general's office) will investigate and assist in prosecuting fraudulent activities against insurance companies. Information about this program can be found on the OIC web site (www.insurance.wa.gov)~~)).

AMENDATORY SECTION (Amending Matter No. R 2010-09, filed 12/22/10, effective 1/22/11)

WAC 284-02-070 ((~~How does the OIC conduct~~)) Hearings((~~?~~)). (1) ((~~**Generally.**~~)) (a) Hearings of the OIC are conducted according to chapter 48.04 RCW and chapter 34.05 RCW, the Administrative Procedure Act ((~~(chapter 34.05 RCW). In addition to general hearings conducted pursuant to RCW 48.04.010,~~)). Two specific types of hearings are conducted pursuant to the Administrative Procedure Act: Rule-making hearings and adjudicative proceedings ((~~or contested case hearings~~)). Adjudicative proceedings include both contested case hearings and other types of adjudicative proceedings which are required by law. Contested case hearings include appeals from disciplinary actions taken by the commissioner.

(b) **How to demand ((~~or request~~)) a hearing.** Under RCW 48.04.010 the commissioner is required to hold a hearing upon demand by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if the failure is deemed an act under the insurance code or the Administrative Procedure Act.

(i) A hearing((~~s~~)) can also be demanded by an aggrieved person based on any report, promulgation, or order of the commissioner.

(ii) ((~~Requests~~)) Demands for hearings must be in writing and delivered to the Tumwater office of the OIC((~~. The request must specify how the person making the demand has been aggrieved by the commissioner, and must specify the grounds to be relied upon as the basis for the relief sought~~)) by mail, hand delivery, facsimile, or e-mail. Unless a person aggrieved by an order of the commissioner demands a hearing within ninety days after receiving notice of that order, or in the case of persons or entities authorized by the OIC to transact the business of insurance under Title 48 RCW, within ninety days after the order was mailed to the most recent address shown in the OIC's licensing records, the right to a hearing is conclusively deemed to have been waived. A hearing is considered demanded when the demand for hearing is received by the commissioner.

(c) Accommodation will be made for persons needing assistance((~~, for example, where English is not their primary language, or for hearing impaired persons~~)) due to difficulty with language or disability.

(2) **((~~Proceedings~~)) Procedural and substantive requirements for adjudicative proceedings including contested cases ((~~or adjudicative hearings~~)).**

(a) Provisions ((~~specifically relating~~)) applicable to ((~~disciplinary~~)) adjudicative proceedings are contained in chapter 48.04 RCW and chapter 34.05 RCW, the Administrative Procedure Act, and chapter 10.08 WAC.

(b) Substantive provisions specifically relating to action taken against persons or entities authorized by the OIC to transact the business of insurance are contained in RCW 48.17.530, 48.17.540, 48.17.550, 48.17.560, chapter 48.102 RCW, and other chapters related to specific licenses. ((~~Provisions applicable to other adjudicative proceedings are contained in chapter 48.04 RCW and the Administrative Procedure Act (chapter 34.05 RCW). The uniform rules of practice and procedure appear in Title 10 of the Washington Administrative Code.~~)) The grounds for disciplinary action against insurance producers, title insurance agents and adjusters are contained in RCW 48.17.530 and 48.17.540(1); grounds for disciplinary action against surplus line brokers are contained in RCW 48.15.140; grounds for similar action against insurance companies are contained in RCW 48.05.130 and 48.05.-140; grounds for actions against fraternal benefit societies are found ((~~at~~)) in RCW ((~~48.36A.300 (domestic) and RCW~~)) 48.36A.310 ((~~(foreign)~~)); grounds for actions against life settlement providers are found in chapter 48.102 RCW; grounds for actions against health care service contractors are contained in RCW 48.44.160; ((~~and~~)) grounds for action against health maintenance organizations are contained in RCW 48.46.130((~~.~~)); grounds for actions against other persons or entities authorized by the OIC under Title 48 RCW are found in the chapters of Title 48 RCW applicable to those licenses; grounds for action against unauthorized individuals or entities are found generally throughout Title 48 RCW.

((~~(b)~~)) (c) The ((~~insurance~~)) commissioner may suspend or revoke any license, certificate of authority, or registration issued by the OIC. In addition, the commissioner may generally levy fines against any persons or organizations having been authorized by the OIC.

((~~(c)~~)) (d) Adjudicative proceedings or contested case hearings of the insurance commissioner are informal in nature, and compliance with the formal rules of pleading and evidence is not required.

(i) The insurance commissioner may delegate the authority to hear and determine the matter and enter the final order under RCW 48.02.100 and 34.05.461 to a presiding officer((~~; or~~)). The commissioner may appoint a chief hearing officer who will have primary responsibility for the conduct of hearings, the procedural matters preliminary thereto, and the preservation of hearing records. The position of hearing officer does not report to any of the major divisions of the OIC. The commissioner may also use the services of an administrative law judge in accordance with chapter 34.12 RCW and chapter 34.05 RCW, the Administrative Procedure Act ((~~(chapter 34.05 RCW)~~)). The initial order of an administrative law judge will not become a final order without the commissioner's review (RCW 34.05.464) and entry of a final order.

(ii) The hearing will be recorded by any method chosen by the presiding officer. Except as required by law, the OIC is not required, at its expense, to prepare a transcript. Any party, at the party's expense, may cause a reporter approved by the presiding officer to prepare a transcript from the agency's record, or cause additional recordings to be made during the hearing if, in the opinion of the presiding officer, the making of the additional recording does not cause distraction or disruption. If appeal from the insurance commissioner's order is made to the superior court, the recording of the hearing will be transcribed and certified to the court after confirmation of payment of all costs for the transcription by the appellant.

(iii) The ((~~insurance~~)) commissioner or the presiding officer may allow any person affected by the hearing to be present during the giving of all testimony and will allow the aggrieved person a reasonable opportunity to inspect all documentary evidence, to examine witnesses, and to present evidence. Any person heard must make full disclosure of the facts pertinent to the inquiry under oath.

(iv) ((~~Unless a person aggrieved by an order of the insurance commissioner demands a hearing within ninety days after receiving notice of that order, or in the case of persons or entities authorized by the OIC to transact the business of insurance under Title 48 RCW, within ninety days after the order was mailed to the most recent address shown in the OIC's licensing records, the right to a hearing is conclusively deemed to have been waived (RCW 48.04.010(3)).~~

~~(v)~~)) Prehearing or other conferences for settlement or simplification of issues may be held at the discretion and direction of the presiding officer.

((~~(d)~~)) (e) Discovery is available in adjudicative proceedings ((~~and contested cases~~)) pursuant to Civil Rules 26 through 37 as now or hereafter amended without first obtaining the permission of the presiding officer or the administrative law judge in accordance with RCW 34.05.446(2).

(i) Civil Rules 26 through 37 are adopted and incorporated by reference in this section, with the exception of CR 26 (j) and (3) and CR 35, which are not adopted for purposes of this section.

(ii) The presiding officer or administrative law judge is authorized to make any order that a court could make under CR 37 (a) through (e), including an order awarding expenses of the motion to compel discovery or dismissal of the action.

(iii) This rule does not limit the presiding officer's or administrative law judge's discretion and authority to condition or limit discovery as set forth in RCW 34.05.446(3).

(3) **Rule-making hearings.** Rule-making hearings are conducted based on requirements found in chapter 34.05 RCW, the Administrative Procedure Act ((~~(chapter 34.05 RCW)~~)) and chapter 34.08 RCW (the State Register Act).

(a) Under applicable law all interested parties must be provided an opportunity to express their views concerning a proposed rule, either orally or in writing. The OIC will accept comments on proposed rules by mail, ((~~electronic~~)) telefacsimile ((~~transmission~~)), or ((~~electronic mail~~)) e-mail but will not accept comments by recorded telephonic communication or voice mail (RCW 34.05.325(3)).

(b) Notice of intention of the insurance commissioner to adopt a proposed rule or amend an existing rule is published in the state register and is sent to anyone who has requested notice in advance and to persons who the OIC determines would be particularly interested in the proceeding. Persons requesting paper copies of all proposed rule-making notices of inquiry and hearing notices may be required to pay the cost of mailing these notices (RCW 34.05.320(3)).

(c) Copies of proposed new rules and amendments to existing rules as well as information related to how the public may file comments are available on the OIC web site ((~~(~~))www.insurance.wa.gov((~~)~~)).

AMENDATORY SECTION (Amending Matter No. R 2003-09, filed 12/14/06, effective 1/14/07)

WAC 284-02-100 ((~~How can an interested person~~)) Petition for adoption, amendment, or repeal of rules((~~?~~)). (1) ((~~As authorized by the Administrative Procedure Act,~~)) Any ((~~interested~~)) person may petition the insurance commissioner requesting the adoption, amendment, or repeal of any rule ((~~(~~))using the procedures set forth in RCW 34.05.-330((~~)~~)). The petition must be in writing, dated, and signed by the petitioner. In addition to the information listed in RCW 34.05.330(3), each petition must include the following information:

(a) The name and address of the person requesting the action, and, if relevant, the background and identity of the petitioner and the interest of the petitioner in the subject matter of the rule;

(b) The full text of any proposed new or amendatory rule and the citation and caption of any existing rule to be amended or repealed;

(c) A narrative explaining the purpose and scope of any proposed new or amendatory rule including a statement generally describing the statutory authority relied upon by the petitioner, how the rule is to be implemented, the reasons for the proposed action, accompanied by necessary or pertinent data in support of the new rule or amendment; and

(d) Statements from other persons in support of the action petitioned are encouraged, if they help the OIC to understand why the new rule or amendment is needed.

(2)((~~(a) Within sixty days after the petition to adopt, amend, or repeal any rule is submitted, the OIC either:~~

~~(i) Will formally deny the petition in writing to the person requesting the action, stating the reasons for the denial, and, if appropriate, will state any alternative means by which the insurance commissioner will address concerns raised; or~~

~~(ii) Will initiate rule-making proceedings in accordance with the Administrative Procedure Act.~~

~~(b) If the insurance commissioner denies a petition to repeal or amend a rule, the petitioner may appeal the denial to the governor, within thirty days after the denial (RCW 34.05.330(2)).~~

~~(3) If the insurance commissioner determines it to be in the interest of the public, a hearing may be held for the further consideration and discussion of the requested adoption, amendment, or repeal of any rule.~~

~~(4)~~)) For information concerning the subjects of rules being proposed, or to request paper copies of rules or copies of materials presented to the commissioner during the rule-making process, members of the public may contact the agency's rules coordinator. The name, address, and phone number of the rules coordinator are available on the OIC web site and are published at least annually in the *Washington State Register*. Complete information regarding all rules being proposed is available on the OIC web site ((~~(~~))www. insurance.wa.gov((~~)~~)).

AMENDATORY SECTION (Amending Matter No. R 2008-10, filed 7/2/08, effective 8/2/08)

WAC 284-02-105 ((~~What does "~~))Sending((~~"~~)) or ((~~"~~))delivery((~~" include?~~)) of information to the commissioner. ((~~Throughout~~)) For purposes of complying with Titles 48 RCW and 284 WAC, whenever written notice to the commissioner is required ((~~to be sent or delivered to the commissioner~~)), "sending" or "delivery" of the written notice includes transmitting the required information in writing and, where appropriate, on forms designated by the commissioner for that purpose via first class mail, commercial parcel delivery company, ((~~electronic~~)) telefacsimile, or e-mail, unless the relevant requirement specifies sending the written notice in some specific manner, such as via first class mail, postage prepaid. Delivery occurs when the commissioner's staff receives the written notice and is evidenced by a stamp confirming receipt, signing a receipt, or opening an e-mail.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 284-02-023	How is the OIC organized?
WAC 284-02-025	How is the OIC funded?
WAC 284-02-030	How can service of process over foreign and alien insurers be made?
WAC 284-02-040	Where can information about applying for a license as an adjuster or insurance producer, surplus line broker or title insurance agent be found?
WAC 284-02-050	Where can information and applications for admission as an authorized insurer, fraternal benefit society, health care service contractor, health maintenance organization, viatical settlement provider, and for other entities required to be authorized to transact the business of insurance be found?
WAC 284-02-060	Where can information regarding filing a complaint against a company, insurance producer, surplus line broker, title insurance agent, adjuster, or other person or entity authorized by the OIC be found?
WAC 284-02-080	What publications and information are available from the OIC?

WSR 12-06-077
PROPOSED RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Docket TV-111493—Filed March 7, 2012, 9:06 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 11-17-140.

Title of Rule and Other Identifying Information: Chapter 480-15 WAC, Household goods carriers.

Hearing Location(s): Commission Hearing Room 206, Second Floor, Richard Hemstad Building, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504-7250, on April 26, 2012, at 1:30 p.m.

Date of Intended Adoption: April 26, 2012.

Submit Written Comments to: Washington Utilities and Transportation Commission, 1300 South Evergreen Park Drive S.W., P.O. Box 47250, Olympia, WA 98504-7250, e-mail records@utc.wa.gov, fax (360) 586-1150, by April 9, 2012. Please include "Docket TV-111493" in your comments.

Assistance for Persons with Disabilities: Contact Debbie Aguilar by April 12, 2012, TTY (360) 586-8203 or (360) 664-1132.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The Washington Movers Conference, a division of the Washington Trucking Association, requested the utilities and transportation commission (UTC) consider a rule making to review its rules on household goods entry standards.

Entry standards for household goods carriers are minimal. Applicants must properly complete the application, pay the fee, and provide proof of both liability and cargo insurance. Once these simple steps are completed, the UTC grants a permit. The existing rules may be insufficient, perhaps granting permits to companies that are unfit to operate.

Reasons Supporting Proposal: The proposed rules would set standards that allow qualified companies to operate and, at the same time, protect the public from unscrupulous, unsafe, or unfit household goods moving companies.

Statutory Authority for Adoption: RCW 80.01.040, 81.04.160, and 81.80.075.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: UTC, governmental.

Name of Agency Personnel Responsible for Drafting: Vicki Elliott, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504, (360) 664-1119; Implementation and Enforcement: David W. Danner, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504, (360) 664-1208.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rules will not result in or impose more than minor costs. Because there will not be more than minor increase in costs resulting from the proposed rule changes, a small business economic impact statement is not required under RCW 19.85.030(1).

A cost-benefit analysis is not required under RCW 34.05.328. The commission is not an agency to which RCW 34.05.328 applies. The proposed rules are not significant legislative rules of the sort referenced in RCW 34.05.328(5).

March 7, 2012

David W. Danner

Executive Director and Secretary

AMENDATORY SECTION (Amending Docket TV-070466, General Order R-547, filed 12/27/07, effective 1/27/08)

WAC 480-15-185 Types of household goods permits. ((~~The commission may issue any of the following types of permits:~~

~~(1) **Emergency temporary authority** for a period of thirty days or less when there is an urgent need for service and time or circumstances do not reasonably allow filing and processing an application for temporary authority.~~

~~(2) **Temporary authority** for up to one hundred eighty days to meet a short-term public need or until the commission makes a decision on the pending application for permanent authority. The applicant must be fit, willing and able and the proposed service must be in the public interest.~~

~~(3) **Permanent authority** has no expiration date or renewal requirement when the applicant is fit, willing and able to provide service and meets the current or future public convenience and necessity standards.~~)) There are two types of household goods permits.

(1) Provisional permit: An applicant must complete a household goods moving company permit application to receive a provisional permit. A provisional permit lasts for a period of not less than six months. In determining whether to grant provisional authority, the commission will consider the criteria outlined in WAC 480-15-302.

(2) Permanent permit: Once the applicant has held a provisional permit for at least six months, the commission will consider whether to grant the applicant a permanent permit. A permanent permit has no expiration date. The applicant does not need to file a second application for permanent authority. In determining whether to grant permanent authority, the commission will consider the criteria outlined in WAC 480-15-305.

NEW SECTION

WAC 480-15-186 Application required. An applicant must complete a household goods moving company permit application and meet the criteria for a provisional permit and, after the six-month period has passed, a permanent permit, as described in WAC 480-15-185, to be eligible for any of the following:

(1) New authority to operate as a household goods carrier.

(2) Transfer of existing authority, except as described in WAC 480-15-187. If the holder of a permit wishes to transfer the permit, the person or entity receiving the permit must file an application as described in this section. For the purposes of this section and WAC 480-15-187, the person or entity receiving the permit is the applicant.

(3) Acquisition of control of existing authority.

(4) Additional authority for an existing household goods permit.

NEW SECTION

WAC 480-15-187 Transfer of an existing permit. (1) If the holder of a permit wishes to transfer the permit, the person or entity receiving the permit must file an application as described in this section. For the purposes of WAC 480-15-186 and this section, the person or entity receiving the permit is the applicant.

(2) The commission will grant an application to transfer existing permanent authority, or acquire control of existing permanent authority, without requiring a provisional permit, public notice, or comment if the applicant is fit, willing, and able to provide service and the applicant has filed to transfer or acquire control of permanent authority for any one of the following reasons:

(a) A partnership has dissolved due to the death, bankruptcy or withdrawal of a partner and that partner's interest is being transferred to a spouse or to one or more remaining partners.

(b) A shareholder in a corporation has died and that shareholder's interest is being transferred to a surviving spouse or one or more surviving shareholders.

(c) A sole proprietor has died, the sole proprietor devised or bequeathed the company by will, and the applicant is seeking transfer of the permit in accordance with the bequest or devise set forth in the will.

(d) An individual has incorporated and the same individual remains the majority shareholder.

(e) An individual has added a partner but the same individual remains the majority partner.

(f) A corporation has dissolved and the interest is being transferred to the majority shareholder.

(g) A partnership has dissolved and the interest is being transferred to the majority partner.

(h) A partnership has incorporated, and the partners are the majority shareholders.

(i) Ownership is being transferred from one corporation to another corporation when both are wholly owned by the same shareholders.

(2) The commission will grant an application for permanent authority without requiring a provisional permit after the application has been published on the application docket subject to comment for thirty days if the applicant is fit, willing, and able to provide service, the applicant has filed to transfer or acquire control of permanent authority, and all of the following conditions exist:

(a) Ownership or control of a permit is being transferred to any shareholder, partner, family member, employee, or other person familiar with the company's operations and the household goods moving services provided.

(b) The permit has been actively used by the current owner to provide household goods moving services during the twelve-month period prior to the application.

(c) The application includes a certified statement from the applicant and the current owner explaining why the transfer of ownership or control is necessary to ensure the company's economic viability.

(d) The application includes a certified statement from the applicant and the current owner describing the steps taken by the parties to ensure that safe operations and continuity of service to customers is maintained.

AMENDATORY SECTION (Amending Docket TV-070466, General Order R-547, filed 12/27/07, effective 1/27/08)

WAC 480-15-190 Service territory. Household goods permits authorize statewide operations unless:

(1) ((~~You~~)) An applicant elects to limit ((~~your~~)) the service territory to specific counties; or

(2) The commission, by order, limits ((~~your~~)) an applicant's service territory.

AMENDATORY SECTION (Amending Docket TV-070466, General Order R-547, filed 12/27/07, effective 1/27/08)

WAC 480-15-230 Application fees. Application fees are:

Type of Permit Application:	Fee:
((~~Emergency temporary authority~~	~~$50.00~~
~~Temporary authority~~	~~$250.00~~))
Provisional and permanent authority. The fee for provisional, and then permanent, authority is a one-time fee	$550.00
Transfer or acquisition of authority under WAC ((~~480-15-335~~)) 480-15-186 and 480-15-187	$250.00
Permit reinstatement ((~~(~~))under ((~~provisions of~~)) WAC 480-15-450((~~)~~))	$250.00
Name change only	$35.00

Part 2.2 - ((~~Emergency Temporary and Temporary Authority~~)) Permanent Authority

NEW SECTION

WAC 480-15-302 Provisional authority. The commission will grant provisional authority to any applicant that meets the following criteria:

(1) The applicant has properly completed the household goods moving company permit application.

(2) The application does not contain any indication of fraud, misrepresentation, or erroneous information.

(3) The applicant has provided a copy of a valid Washington state driver's license for each person named in the application associated with the proposed moving company.

(4) The applicant has provided evidence that the applicant possesses sufficient financial resources to operate a moving company. The commission will accept as evidence the completed financial statement form included in the household goods moving company permit application or the alternative documents listed on the financial statement form.

(5) The applicant has met the liability and cargo insurance requirements of WAC 480-15-530 and 480-15-550.

(6) The applicant has provided evidence of compliance with state tax, labor, employment, business, and vehicle licensing laws and rules. The commission will accept valid account numbers that staff can verify, showing the applicant has established accounts with other state agencies, as evidence.

(7) The applicant has provided evidence of its enrollment in a drug and alcohol testing program, or evidence that it has in place its own drug and alcohol testing program, if required by WAC 480-15-570. The commission will accept proof of enrollment in a program, or a detailed description of the applicant's own program, as evidence.

(8) Commission staff has completed a criminal background check on each person named in the application associated with the proposed moving company. The commission will not grant provisional authority if any named person has, within the past five years, been convicted of any crime involving theft, burglary, sexual misconduct, identity theft, fraud, false statements, or the manufacture, sale, or distribution of a controlled substance.

(9) The applicant owns or leases the equipment necessary to provide household goods moving services.

(10) The commission has not denied a household goods moving company permit application within the previous six months filed by the same applicant or by any other person named on the application.

(11) The commission has not canceled, for cause, a permit held by the applicant, or by any other person named on the application, within the previous one year.

(12) The applicant has filed with the application at least three completed statements of support for the proposed service.

(13) No other circumstances exist that cause the commission to deny the application.

NEW SECTION

WAC 480-15-305 Permanent authority. The commission will grant permanent authority to any applicant that meets the following criteria:

(1) The applicant has met all of the criteria required for a provisional permit as described in WAC 480-15-302.

(2) The applicant has completed a provisional period of not less than six months.

(3) The applicant has attended a commission-sponsored household goods carrier training class.

(4) The applicant has provided commission staff with evidence that the applicant has completed a criminal background check on each person it employs or intends to employ that will have contact with a customer or a customer's residence. The commission will not grant permanent authority if any employee has, within the past five years, been convicted of any crime involving theft, burglary, sexual misconduct, identity theft, fraud, false statements, or the manufacture, sale, or distribution of a controlled substance.

(5) The applicant has received a satisfactory safety rating in a safety review conducted by commission safety staff.

(6) The applicant has no outstanding commission-issued monetary penalties.

(7) The applicant has paid all outstanding fees or other amounts due to the commission.

(8) The applicant has met all other commission regulatory requirements, including any requirements set by statute, rule, tariff, or order.

(9) The applicant has no unresolved consumer complaints on file with the commission.

(10) No other circumstances exist that cause the commission to deny permanent authority.

Part 2.3 - ((~~Permanent Authority~~)) Using the Permit

AMENDATORY SECTION (Amending Docket TV-070466, General Order R-547, filed 12/27/07, effective 1/27/08)

WAC 480-15-340 Commenting on an application for permanent authority. (1) The commission publishes applications for permanent authority in the application docket that it mails to each applicant and, upon written request, to any other person interested in application proceedings.

(2) Anyone having an interest in an application appearing on the docket may file written comments within thirty days following publication, unless the application is published in conjunction with a grant of ((~~temporary~~)) provisional authority. If the permanent authority application is published in conjunction with a grant of ((~~temporary~~)) provisional authority, then comments will be accepted for one hundred eighty days or the full term of the ((~~temporary~~)) provisional permit.

(3) Comments may either support or protest the application. Comments must include the commenter's full name, address, telephone number, e-mail address, fax number, and permit number, if available. Comments must be signed and indicate the place and date when they were signed. Comments must indicate support for, or protest of, the permanent authority for any one or more of the following reasons:

(a) Fitness.

(b) Public interest.

(c) Levels of service.

(d) Business practices.

(e) Safety.

(f) Operation of equipment.

(g) Current or future public need for service.

(4) A comment protesting an application will not, on its own, cause the commission to set the matter for a hearing.

Part 2.4 - ((~~Using the Permit~~))
Suspended and Canceled Permits

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 480-15-270	Emergency temporary authority.
WAC 480-15-280	Temporary authority.

WAC 480-15-285	Rejecting or denying an application for temporary authority.
WAC 480-15-290	Granting temporary authority.
WAC 480-15-310	Commenting on actions regarding temporary authority.
WAC 480-15-320	Canceling a temporary permit.
WAC 480-15-330	Permanent authority.
WAC 480-15-335	Exceptions to permanent authority application process.

WSR 12-06-078
PROPOSED RULES
DEPARTMENT OF RETIREMENT SYSTEMS
[Filed March 7, 2012, 9:54 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 11-23-183.

Title of Rule and Other Identifying Information: New WAC 415-700-010 The higher education retirement plan (HERP) supplemental benefit fund, is established.

Hearing Location(s): Department of Retirement Systems (DRS), 6835 Capitol Boulevard, Conference Room 115, Tumwater, WA, on April 11, 2012, at 3:00 p.m.

Date of Intended Adoption: May 1, 2012.

Submit Written Comments to: Ken Goolsby, Rules Coordinator, Department of Retirement Systems, P.O. Box 48380, Olympia, WA 98504-8380, e-mail rules@drs.wa.gov, fax (360) 753-5397, by 5:00 p.m. on April 11, 2012.

Assistance for Persons with Disabilities: Contact Ken Goolsby, rules coordinator, by April 6, 2012, TDD (360) 664-7291, TTY (360) 586-5450, phone (360) 664-7291.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The Washington state legislature has enacted legislation, during the 2011 legislative session, requiring DRS to collect employer contributions from each state institution of higher education and deposit those contributions into a newly established higher education retirement plan supplemental benefit fund.

Reasons Supporting Proposal: The new rule ensures compliance with ESHB 1981, chapter 47, Laws of 2011.

Statutory Authority for Adoption: RCW 41.50.050(5).

Statute Being Implemented: RCW 41.50.030 and 28B.10.423.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: DRS, governmental.

Name of Agency Personnel Responsible for Drafting: Ken Goolsby, P.O. Box 48380, Olympia, WA 98504-8380, (360) 664-7291; Implementation: Shawn Merchant, P.O. Box 48380, Olympia, WA 98504-8380, (360) 664-7303; and Enforcement: George Pickett, P.O. Box 48380, Olympia, WA 98504-8380, (360) 664-7950.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These rules have no effect on businesses.

A cost-benefit analysis is not required under RCW 34.05.328. DRS is not one of the named departments in RCW 34.05.328.

March 7, 2012
Ken Goolsby
Rules Coordinator

Chapter 415-700 WAC

Higher education retirement plan supplemental benefit fund

NEW SECTION

WAC 415-700-010 The higher education retirement plan (HERP) supplemental benefit fund. RCW 28B.10.-423 establishes a higher education retirement plan supplemental benefit fund, in the custody of the state treasurer, for the purpose of funding future higher education retirement plan supplemental benefits.

(1) **Who finances the HERP supplemental benefit fund?** Higher education employers pay into the HERP supplemental benefit fund at an employer contribution rate as established in RCW 28B.10.423 on the salaries paid to employees participating in their HERP.

(2) **Who are the higher education employers?** For the purpose of this section, higher education employers, as defined by RCW 28B.10 includes:

(a) all State universities;

(b) all regional universities;

(c) all State colleges;

(d) all community and technical colleges;

(e) the State Board for Community and Technical Colleges; and

(f) any other higher education entities granted authority for HERP coverage under chapter 28B.10 RCW.

(3) **How are the assets in the HERP supplemental benefit fund invested?** The Washington State Investment Board (WSIB) is responsible for investing HERP supplemental benefit fund assets. For investment purposes, the assets may be commingled with other trust fund accounts in the Commingled Trust Fund (CTF).

(4) **How are assets in the HERP supplemental benefit fund used?** Assets in the HERP supplemental benefit fund are held in trust for the purpose of funding future higher education retirement plan supplemental benefits. Assets will remain in this fund until the Legislature authorizes distribution(s).

(5) **What role does the Department of Retirement Systems (department) have in administering the HERP supplemental benefit fund?** The department will:

(a) Collect employer HERP contributions from higher education employers;

(b) Deposit HERP contributions into the HERP supplemental benefit fund;

(c) Provide buy/sell investment information to WSIB; and

(d) Account for the fund's assets, including each employer's contributions and the earnings on those contributions.

(6) **What information will higher education employers be responsible for reporting to the department?** Each higher education employer will be responsible for reporting the total HERP salaries paid and the contributions owed on those salaries. HERP salaries include the salaries paid to all employees participating in the employer's higher education retirement plan, regardless of employee eligibility for the supplemental benefit portion of the plan.

(7) **Are HERP salaries reportable as they are earned or as they are paid?** HERP salaries are reportable as they are paid.

(8) **When are HERP reports and payment of HERP contributions due to the department?** Reporting and payments of HERP salaries and contributions should coincide with the employer's payroll periods. HERP reports and contribution payments for a calendar month are due on or before the 15th day of the calendar month following payment of the HERP salaries. Reports and contribution payments are considered overdue if not received by the close of business on the third business day after the due date.

Example: A higher education employer pays $50,000 in HERP salaries on January 10th. The same employer pays another $50,000 in HERP salaries on January 25th. The employer must report the HERP salaries paid for both payrolls and make payment of the contributions due on the total combined $100,000 HERP salaries to the department by February 15th.

(9) **Does the department charge interest on overdue payments of contributions for the HERP supplemental benefit fund?** Yes. The department charges interest on overdue contributions to the HERP supplemental benefit fund at the rate of 1% per month simple interest. Interest is charged for each day the payment is overdue. Assessed interest will appear on the employer's monthly accounts receivable statement from the department.

(10) **Can the department charge employers an administrative expense fee for the HERP supplemental benefit fund?** Yes. RCW 41.50.110 authorizes the department to charge employers an administrative expense fee for expenses related to the administration of the HERP supplemental benefit fund.

WSR 12-06-080
PROPOSED RULES
DEPARTMENT OF REVENUE

[Filed March 7, 2012, 11:39 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 10-12-128.

Title of Rule and Other Identifying Information: WAC 458-20-19402 (Rule 19402) Single factor receipts apportionment—Generally and 458-20-19403 (Rule 19403) Apportionable royalty receipts attribution.

Hearing Location(s): Capital Plaza Building, 4th Floor Executive Conference Room, 1025 Union Avenue S.E., Olympia, WA 98504, on April 19, 2012, at 9:00 a.m. Copies of draft rules are available for viewing and printing on our web site at Rules Agenda.

Date of Intended Adoption: April 27, 2012.

Submit Written Comments to: Chris Coffman, e-mail ChrisC@dor.wa.gov, P.O. Box 47453, Olympia, WA 98504-7453, by April 19, 2012.

Assistance for Persons with Disabilities: Contact Mary Carol LaPalm, (360) 725-7499, or Renee Cosare, (360) 725-7514, no later than ten days before the hearing date. For hearing impaired please contact us via the Washington relay operator at (800) 833-6384.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Effective June 1, 2010, chapter 23, Laws of 2010 1st sp. sess., changed Washington's method of apportioning certain gross income from apportionable activities. The department is proposing two new rules, Rules 19402 and 19403, to address the apportionment of income from engaging in apportionable activities as defined in WAC 458-20-19401, except that the apportionment of income received by financial institutions and taxable under RCW 82.04.290 is addressed in WAC 458-20-19404.

Reasons Supporting Proposal: These rules are needed to recognize law changes.

Statutory Authority for Adoption: RCW 82.32.300 and 82.01.060.

Statute Being Implemented: Provisions of chapter 23, Laws of 2010 1st sp. sess. (2ESSB 6143) Part I.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of revenue, governmental.

Name of Agency Personnel Responsible for Drafting: Chris Coffman, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1590; Implementation: Alan R. Lynn, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1599; and Enforcement: Russ Brubaker, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1505.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This rule does not impose any new performance requirements or administrative burden on any small business not required by statute.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rules are not significant legislative rules as defined by RCW 34.05.328.

March 7, 2012
Alan R. Lynn
Rules Coordinator

NEW SECTION

WAC 458-20-19402 Single factor receipts apportionment—Generally.

PART 1. INTRODUCTION.

(101) **General.** RCW 82.04.462 establishes the apportionment method for businesses engaged in apportionable activities and that have nexus with Washington for business

and occupation (B&O) tax liability incurred after May 31, 2010. The express purpose of the change in the law was to require businesses "earn(ing) significant income from Washington residents from providing services" to "pay their fair share of the cost of services that this state renders and the infrastructure it provides." Section 101, chapter 23, 1st special session, 2010.

(102) **Guide to this rule.** This rule is divided into six parts, as follows:

1. Introduction.
2. Overview of single factor receipts apportionment.
3. How to attribute receipts.
4. Receipts factor.
5. How to determine Washington taxable income.
6. Reporting instructions.

(103) **Scope of rule.** This rule applies to the apportionment of income from engaging in apportionable activities as defined in WAC 458-20-19401, except:

(a) To the apportionment of income received by financial institutions and taxable under RCW 82.04.290, which is governed by WAC 458-20-19404; and

(b) To the attribution of royalty income from granting the right to use intangible property, which is governed by WAC 458-20-19403.

(104) **Separate accounting and cost apportionment.** The apportionment method explained in this rule replaces the previously allowed separate accounting and cost apportionment methods. Separate accounting and cost apportionment are not authorized for periods after May 31, 2010.

(105) **Other rules.** Taxpayers may also find helpful information in the following rules:

(a) WAC 458-20-19401 **Minimum nexus thresholds for apportionable activities.** This rule describes minimum nexus thresholds applicable to apportionable activities that are effective after May 31, 2010.

(b) WAC 458-20-19403 **Royalty receipts attribution.** This rule describes the attribution of royalty income for the purposes of single factor receipts apportionment and applies only to tax liability incurred after May 31, 2010.

(c) WAC 458-20-19404 **Single factor receipts apportionment—Financial institutions.** This rule describes the application of single factor receipts apportionment to certain income of financial institutions and applies only to tax liability incurred after May 31, 2010.

(d) WAC 458-20-194 **Doing business inside and outside the state.** This rule describes separate accounting and cost apportionment and applies only to tax liability incurred from January 1, 2006, through May 31, 2010.

(e) WAC 458-20-14601 **Financial institutions—Income apportionment.** This rule describes the apportionment of income for financial institutions for tax liability incurred prior to June 1, 2010.

(106) **Examples.** Examples included in this rule identify a number of facts and then state a conclusion; they should be used only as a general guide. The tax results of all situations must be determined after a review of all the facts and circumstances. The examples in this rule assume all gross income received by the taxpayer is from engaging in apportionable activities. Unless otherwise stated, the examples do not apply to tax liability prior to June 1, 2010.

(107) **Definitions.** The following definitions apply to this rule:

(a) **"Apportionable activities"** has the same meaning as used in WAC 458-20-19401 Minimum nexus thresholds for apportionable activities.

(b) **"Apportionable income"** means apportionable receipts less the deductions allowable under chapter 82.04 RCW.

(c) **"Apportionable receipts"** means gross income of the business from engaging in apportionable activities, including income received from apportionable activities attributed to locations outside this state.

(d) **"Business activities tax"** means a tax measured by the amount of, or economic results of, business activity conducted in a state. The term includes taxes measured in whole or in part on net income or gross income or receipts. In the case of sole proprietorships and pass-through entities, the term includes personal income taxes if the gross income from apportionable activities is included in the gross income subject to the personal income tax. The term "business activities tax" does not include retail sales, use, or similar transaction taxes, imposed on the sale or acquisition of goods or services, whether or not named a gross receipts tax or a tax imposed on the privilege of doing business.

(e) **"Customer"** means a person or entity to whom the taxpayer makes a sale, grants the right to use intangible property, or renders services or from whom the taxpayer otherwise directly or indirectly receives gross income of the business. If the taxpayer performs apportionable services for the benefit of a third party, the term "customer" means the third party beneficiary.

Example 1. Assume a parent purchases apportionable services for their child. The child is the customer for the purpose of determining where the benefit is received.

(f) **"Reasonable method of proportionally attributing"** means a method of determining where the benefit of an activity is received and where the receipts are attributed that is uniform, consistent, and accurately reflects the market, and does not distort the taxpayer's market.

(g) **"State"** means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any foreign country or political subdivision of a foreign country.

(h)(i) **"Taxable in another state"** means either:

(A) The taxpayer is subject to a business activities tax by another state on the taxpayer's income received from engaging in apportionable activity; or

(B) The taxpayer is not subject to a business activities tax by another state on the taxpayer's income received from engaging in apportionable activity, but the taxpayer meets the substantial nexus thresholds described in WAC 458-20-19401 for that state.

(ii) The determination of whether a taxpayer is taxable in a foreign country or political subdivision of a foreign country is made at the country or political subdivision level.

Example 2. Assume Taxpayer A is subject to a business activity tax in State X of Mexico (e.g., Taxpayer pays tax to State X), but nowhere else in Mexico. Also, assume that Taxpayer A is not subject to any national business activity tax in Mexico and does not meet the substantial nexus thresholds

described in WAC 458-20-19401 for Mexico as a whole. In this case, Taxpayer is taxable in State X, but not taxable in any other portion or any other State of Mexico.

Example 3. Assume Taxpayer B is not subject to any business activity taxes in Mexico, but satisfies the substantial nexus thresholds described in WAC 458-20-19401 for Mexico as a whole. Taxpayer B is taxable in all of Mexico.

PART 2. OVERVIEW OF SINGLE FACTOR RECEIPTS APPORTIONMENT.

(201) **Single factor receipts apportionment generally.** Except as provided in WAC 458-20-19404 persons earning apportionable income who have substantial nexus with Washington as specified in WAC 458-20-19401 and who are also taxable in another state must use the apportionment method provided in this rule to determine their taxable income from apportionable activities for B&O tax purposes. Taxable income is determined by multiplying apportionable income from each apportionable activity by the receipts factor for that apportionable activity.

This formula is:

(Taxable income) = (Apportionable income) x (Receipts factor)

See Part 4 of this rule for a discussion of the receipts factor.

(202) **Tax year.** The receipts factor applies to each tax year. A tax year is the calendar year, unless the taxpayer has specific permission from the department to use another period. (RCW 82.32.270.) For the purposes of this rule, "tax year" and "calendar year" have the same meaning.

PART 3. HOW TO ATTRIBUTE RECEIPTS.

(301) **Attribution of receipts generally.** Except as specifically provided for in WAC 458-20-19403 for the attribution of apportionable royalty receipts, this Part 3 explains how to attribute apportionable receipts. Receipts are attributed to states based on a cascading method or series of steps. The department expects that most taxpayers will attribute apportionable receipts based on (a)(i) of this subsection because the department believes that either the taxpayer will know where the benefit is actually received or a "reasonable method of proportionally attributing receipts" will generally be available. These steps are:

(a) Where the customer received the benefit of the taxpayer's service (see subsection (302) of this rule for an explanation and examples of the benefit of the service);

(i) If a taxpayer can reasonably determine the amount of a specific apportionable receipt that relates to a specific benefit of the services received in a state, that apportionable receipt is attributable to the state in which the benefit is received. This may be shown by application of a reasonable method of proportionally attributing the benefit among states. The result determines the receipts attributed to each state. Under certain situations, the use of data based on an attribution method specified in (b) through (f) of this subsection may also be a reasonable method of proportionally attributing receipts among states (see Examples 4 and 5 below).

(ii) If a taxpayer is unable to separately determine or use a reasonable method of proportionally attributing the benefit of the services in specific states under (a)(i) of this subsection, and the customer received the benefit of the service in multiple states, the apportionable receipt is attributed to the state in which the benefit of the service was primarily received. Primarily means, in this case, more than fifty percent.

(b) If the taxpayer is unable to attribute an apportionable receipt under (a) of this subsection, the apportionable receipt must be attributed to the state from which the customer ordered the service.

(c) If the taxpayer is unable to attribute an apportionable receipt under (a) or (b) of this subsection, the apportionable receipt must be attributed to the state to which the billing statements or invoices are sent to the customer by the taxpayer.

(d) If the taxpayer is unable to attribute an apportionable receipt under (a), (b), or (c) of this subsection, the apportionable receipt must be attributed to the state from which the customer sends payment to the taxpayer.

(e) If the taxpayer is unable to attribute an apportionable receipt under (a), (b), (c), or (d) of this subsection, the apportionable receipt must be attributed to the state where the customer is located as indicated by the customer's address:

(i) Shown in the taxpayer's business records maintained in the regular course of business; or

(ii) Obtained during consummation of the sale or the negotiation of the contract, including any address of a customer's payment instrument when readily available to the taxpayer and no other address is available.

(f) If the taxpayer is unable to attribute an apportionable receipt under (a), (b), (c), (d), or (e) of this subsection, the apportionable receipt must be attributed to the commercial domicile of the taxpayer.

(g) The taxpayer may not use an attribution method that distorts the apportionment of the taxpayer's apportionable receipts.

Example 4. Assume Large Law Firm employs hundreds of attorneys and has thousands of clients. It is not commercially reasonable for Large Law Firm to track each charge to each client to determine where the benefit related to each service is received. Assume the scope of Large Law Firm's practice is such that it is reasonable to assume that the benefits of Large Law Firm's services are received at the location of the customer as reflected by the customer's billing address. Under these circumstances, Large Law Firm can use the billing addresses of each client as a reasonable method of proportionally attributing the benefit of its services.

Example 5. Same facts as Example 4 except, Large Law Firm has a single client that represents a statistically significant portion of its revenue and whose billing address is unrelated to any of the services provided. In this case, using the billing address of this client would not relate to the benefit of

the services. Using the billing address for this client to determine where the benefit is received would significantly distort the apportionment of Large Law Firm's receipts. Therefore, Large Law Firm would need to evaluate the specific services provided to that client to determine where the benefits of those services are received and may use billing address to attribute the income received from other clients.

Example 6. Assume Taxpayer R attributes an apportionable receipt based on its customer's billing address, using (c) of this subsection, and the billing address is a P.O. Box located in another state. Taxpayer R also knows that mail delivered to this P.O. Box is automatically forwarded to the customer's actual location. In this case, use of the billing address is not allowed because it would distort the apportionment of Taxpayer R's receipts.

(302) **Benefit of the service explained.** The first two steps (subsection (301)(a)(i) and (ii) of this rule) used to attribute apportionable receipts to a state are based on where the taxpayer's customer receives the benefit of the service. This subsection explains the framework for determining where the benefit of a service is received.

(a) **If the taxpayer's service relates to real property, then the benefit is received where the real property is located.** The following is a nonexclusive list of services that relate to real property:

(i) Architectural;

(ii) Surveying;

(iii) Janitorial;

(iv) Security;

(v) Appraisals; and

(vi) Real estate brokerage.

(b) **If the taxpayer's service relates to tangible personal property, then the benefit is received where the tangible personal property is located or intended/expected to be located.**

(i) Tangible personal property is generally treated as located where the place of principal use occurs. If the tangible personal property is subject to state licensing (e.g., motor vehicles), the principal place of use is presumed to be where the property is licensed; or

(ii) If the tangible personal property will be created or delivered in the future, the principal place of use is where it is expected to be used or delivered.

(iii) The following is a nonexclusive list of services that relate to tangible personal property:

(A) Designing specific/unique tangible personal property;

(B) Appraisals;

(C) Inspections of the tangible personal property;

(D) Testing of the tangible personal property;

(E) Veterinary services; and

(F) Commission sales of tangible personal property.

(c) **If the taxpayer's service does not relate to real or tangible personal property, the service is provided to a customer engaged in business, and the service relates to the customer's business activities, then the benefit is received where the customer's related business activities occur.** The following is a nonexclusive list of business related services:

(i) Developing a business management plan;

(ii) Commission sales (other than sales of real or tangible personal property);

(iii) Debt collection services;

(iv) Legal and accounting services not specific to real or tangible personal property;

(v) Advertising services; and

(vi) Theatre presentations.

(d) **If the taxpayer's service does not relate to real or tangible personal property, is either provided to a customer not engaged in business or unrelated to the customer's business activities, and:**

(i) The service requires the customer to be physically present, then the benefit is received where the customer is located when the service is performed. The following is a nonexclusive list of services that require the customer to be physically present:

(A) Medical examinations;

(B) Hospital stays;

(C) Haircuts; and

(D) Massage services.

(ii) The taxpayer's service relates to a specific, known location(s), then the benefit is received at those location(s). The following is a nonexclusive list of services related to specific, known location(s):

(A) Wedding planning;

(B) Receptions;

(C) Party planning;

(D) Travel agent and tour operator services; and

(E) Preparing and/or filing state and local tax returns.

(iii) If (d)(i) and (ii) of this subsection do not apply, the benefit of the service is received where the customer resides. The following is a nonexclusive list of services whose benefit is received at the customer's residence:

(A) Drafting a will;

(B) Preparing and/or filing federal tax returns;

(C) Selling investments; and

(D) Blood tests (not blood drawing).

(e) **Special rule for extension of credit.** See subsection (304) of this rule for special rules attributing income related to loans (secured and unsecured) and credit cards that is received by persons who are not financial institutions as defined in WAC 458-20-19404.

(303) **Examples of the application of the benefit of service analysis and reasonable methods of proportionally attributing receipts.**

(a) **Services related to real property:**

Example 7. Architect drafts plans for a building to be built in Washington. Architect's services relate to real property which is located in Washington, therefore the customer receives the benefit of that service in Washington at the location of the real property. Architect's receipts for this service are solely attributed to Washington because the entire benefit is received in Washington.

Example 8. Franchisor hires Taxpayer, an architect, to create a design of a standardized building that will be used at four locations in Washington and two locations in Oregon. Taxpayer's services relate to real property at those six locations, therefore the customer receives the benefit of the service at the four Washington locations and the two Oregon locations. Taxpayer will attribute 2/3 (4 of 6 sites) of the

receipts for this service to Washington and 1/3 (2 of 6 sites) of the receipts to Oregon.

Example 9. Assume the same facts as Example 8 except Franchisor will use the same design in all 50 states for all its franchisee's locations. Taxpayer and Franchisor do not know at the time the service is provided (and cannot reasonably estimate) how many franchise locations will exist in each state. Therefore, there is no reasonable means of proportionally attributing receipts at the time the services are performed and it is clear that no state will have a majority of the franchise locations. Accordingly, the apportionable receipts must be attributed following the steps in subsection (301)(b) through (f) of this rule.

Example 10. Real estate broker located in Florida receives a commission for arranging the sale of real property located in Washington. The real estate broker's service is related to the real property, therefore the benefit is received in Washington, where the real property is located, and the commission income is attributed to Washington.

(b) **Services related to tangible personal property.**

Example 11. Big Manufacturing hires an engineer to design a tool that will only be used in a factory located in Brewster, Washington. Big Manufacturing receives the benefit of the engineer's services at a single location in Washington where the tool is intended to be used. Therefore, 100% of engineer's receipts from this service must be attributed to Washington.

Example 12. The same facts as in Example 11, except Big Manufacturing will use the tool equally in factories located in Brewster and in Kapa'a, Hawai'i. Therefore, Big Manufacturer receives the benefit of the service equally in two states. Because the benefit of the service is received equally in both states, a reasonable method of proportionally attributing receipts would be to attribute 1/2 of the receipts to each state.

Example 13. Taxpayer, a commissioned salesperson, sells tangible personal property (100 widgets) for Distributor to XYZ Company for delivery to Spokane. Distributor receives the benefit of Taxpayer's service where the tangible personal property will be delivered. Therefore, Taxpayer will attribute the commission from this sale to Washington.

Example 14. Same facts as in Example 13, but the widgets are to be delivered 50 to Spokane, 25 to Idaho, and 25 to Oregon. In this case, the benefit is received in all three states. Taxpayer shall attribute the receipts (commission) from this sale 50% to Washington, 25% to Idaho, and 25% to Oregon where the tangible personal property is delivered to the buyer.

Example 15. Training Company provides training to Customer's employees on how to operate a specific piece of equipment used solely in Washington. Customer receives the benefit of the service where the equipment is used, which is in Washington. Therefore, Training Company will attribute 100% of its receipts received from Customer to Washington.

(c) **Services related to customer's business activities.**

Example 16. Manufacturer hires Law Firm to defend Manufacturer in a class action product liability lawsuit involving Manufacturer's Widgets. The benefit of Law Firm's services relates to Manufacturer's widget selling activity in various states. A reasonable method of proportionally attributing receipts in this case would be to attribute the receipts to the locations where the Manufacturer's Widgets were delivered, which relates to Manufacturer's business activities.

Example 17. Debt Collector provides debt collection services to ABC. The benefit of Debt Collector's services relates to ABC's selling activity in various states. It is reasonable to assume that where the debtors are located is the same as where ABC's business activity occurred. If Debt Collector is able to attribute specific receipts to a specific debtor, then the receipt is attributed to where the debtor is located.

Example 18. Same facts as Example 17, except Debt Collector is unable to attribute specific benefits with specific debtors. In this case, a reasonable method of proportionally attributing benefits/receipts should be employed. Depending on Debt Collector's specific facts and circumstances, a reasonable method of proportionally attributing benefits/receipts could be: Relative number of debtors in each state; relative debt actually collected from debtors in each state; the relative amount of debt owed by debtors in each state; or another method that does not distort the apportionment of Debt Collector's receipts.

Example 19. Training Company provides training to Customer's employees who are all located in State A. The training is provided in State B. The training relates to the employees' ethical behavior within Customer's organization. Customer receives the benefit of Training Company's service in State A, where Customer's office is located and the employees presumably practice their ethical behavior. Training Company must attribute the apportionable receipts to State A where the benefit is solely received.

Example 20. Same facts as Example 19, except the training is provided for employees from several states and Training Company knows where each employee works. The benefit of the Training Company's services is received in those several states. Attributing receipts from the training based on where the employees work is a reasonable method of proportionally attributing the receipts income.

Example 21. Call Center provides "customer service" services to Retailer who has customers in all 50 states. Call Center's services relate to Retailer's selling activity in all 50 states, therefore Retailer receives the benefit of Call Center's services in all 50 states. Call Center has offices in Iowa and Alabama that answer questions about Retailer's products. Call Center records Retailer's customer's calls by area code. Call Center may attribute receipts received from Retailer based on the number of calls from area codes assigned to each state. This would be a reasonable method of proportionally attributing receipts notwithstanding the fact that mobile phone numbers and related area codes may not exactly reflect the physical location of the customer in all cases.

Example 22. Taxpayer provides internet advertising services to national retail chains, regional businesses, businesses with a single location, and businesses that operate solely over the Internet. Generally, the benefit of the advertising services is received where the customer's related business activities occur.

Example 23. Oregon Newspaper sells newspaper advertising to Merlin's Potion Shop. Merlin's only makes over-the-counter sales from its single location in Vancouver, Washing-

ton. Merlin's Potion Shop receives the benefit of the Oregon Newspaper's advertising services in Washington where it makes sales to its customers. In this case Oregon Newspaper will report 100% of its receipts received from Merlin's to Washington.

Example 24. Management Company provides general professional services (e.g., accounting, finance, and human resources) to Racko, Inc. which has three offices that use those services in Washington, Oregon, and Idaho. Racko sells widgets and has customers for its widgets in all 50 states. However, the services provided by Management Company do not directly relate to Racko's customer facing business activity. On the contrary, Management Company's services relate to Racko's internal business activity conducted at its office locations. Accordingly, the benefit of the service performed by Management Company is received at Racko's locations in Washington, Oregon, and Idaho. Assuming that each office is approximately the same size and uses the services to approximately the same extent, then attributing 1/3 of the receipts to each of the states in which Racko has locations using the services is a reasonable method of proportionally attributing Management Company's receipts from Racko.

Example 25. Director serves on the board of directors for DEF, Inc. Director's services relate to the general management of DEF, Inc. DEF, Inc. is Director's customer and receives the benefit of Director's services at its corporate domicile. Therefore, Director must attribute the receipts earned from Director's services to DEF to DEF's corporate domicile.

(d) **Services not related to real or tangible personal property and either provided to customers not engaged in business or unrelated to the customer's business activities.**

Example 26. A Washington resident travels to California for a medical procedure. Because the Washington resident must be physically in California, the Washington resident receives the benefit of the service in California. Therefore, the service provider must attribute its income from the procedure to California.

Example 27. Washington accountant prepares a Nevada couple's Arizona and Oregon state income tax returns as well as their federal income tax return. The benefit of the accountant's service associated with the state income tax returns is attributed to Arizona and Oregon because these returns relate to specific locations (states). The benefit associated with the federal income tax return is attributed to the couple's residence. The fees for the state tax returns are attributed to Arizona and Oregon, respectively, and the fee for the federal income tax return is attributed to Nevada.

Example 28. Tour Operator provides cruises through Washington's San Juan Islands for four days and Victoria, British Columbia for one day. The benefit of the tour is received where the tour occurs. Tour Operator may use a reasonable method of proportionally attributing the benefit to determine that its customers receive 80% of the benefit in Washington and 20% outside of Washington. Therefore, Tour Operator must attribute 80% of apportionable receipts to Washington and 20% to British Columbia.

Example 29. Travel Agent arranges a vacation package for Joe. Joe will travel to Seattle for 4 days and then to Alaska for 6 days and return home to Oregon. Joe receives the benefit of the travel agent services where he will travel. Joe receives 40% of the benefit of Travel Agent's services in Washington and 60% in Alaska. Therefore, Travel Agent must attribute 40% of the receipts from Joe's trip to Washington and 60% to Alaska.

Example 30. A Washington couple hires a Washington attorney to prepare a last will and testament for Daughter who lives in California. Daughter is a third-party beneficiary and receives the benefit of the attorney's services in California because that is where Daughter lives. Washington Attorney must attribute the fee to California.

Example 31. A Washington couple hires a California accountant to prepare their joint federal income tax return. Because the couple does not have to be physically present for the accountant to perform services and services are not related to a specific location, the Washington couple receives the benefit of the accountant's services at their residence in Washington. California accountant must attribute its fee for this service to Washington.

Example 32. An Arizona resident retains a Washington stock broker to handle its investments. The stock broker receives orders from the client and executes trades of securities on the New York Stock Exchange. Because (a) the Arizona resident is not investing as part of a business; (b) the activity does not relate to real or tangible personal property; (c) and the client does not need to be physically present for the stock broker to perform its services; and (d) the services are not related to a specific location, the client receives the benefit of the services at client's place of residence. Washington stockbroker must attribute the fee to Arizona.

Example 33. Investment Manager manages a mutual fund. Investment Manager receives a fee for managing the fund based on the value of the assets in the fund on particular days. Investment Manager knows or should know the identity of the investors in the fund and their mailing addresses. The fees received by Investment Manager (whether from the mutual fund or from individual investor's accounts) are for the services provided to the investors. Investment Manager's services do not relate to real or tangible personal property and do not require that the client be physically present, therefore, the benefit of Investment Manager's services is received where the investors are located and Investment Manager's apportionable receipts must be attributed to those locations.

(304) **Special rules related to extending credit performed by nonfinancial institutions.** Businesses not included in the definition of a financial institution under WAC 458-20-19404 that provide services related to the extension of credit must attribute their income from such activities as follows:

(a) **Activities related to extending credit where real property secures the debt.** Such activities include, but are not limited to, servicing loans, making loans subject to deeds of trust or mortgages (including any fees in the nature of interest related to the loan), and buying and selling loans. Apportionable receipts from these activities are attributed in the same manner as a financial institution attributes these apportionable receipts under WAC 458-20-19404.

(b) **Activities related to credit cards.** Such activities include, but are not limited to, issuing credit cards, servicing, and billing. Apportionable receipts from these activities are attributed to the billing address of the card holder.

(c) **Other activities related to extending credit where real property does not secure the debt.** Such activities include, but are not limited to, servicing loans, making loans (including any fees related to such loans), and buying and selling loans. Apportionable receipts from these activities are attributed in the same manner a financial institution attributes income under WAC 458-20-19404.

(d) **All other apportionable receipts from such businesses are attributed using subsections (301) through (303) of this rule or WAC 458-20-19403.**

(305) **What does "unable to attribute" mean?** A taxpayer is "unable to attribute" apportionable receipts when the taxpayer has no commercially reasonable means to acquire the information necessary to attribute the apportionable receipts. Cost and time may be considered to determine whether a taxpayer has no commercially reasonable means to acquire the information necessary to attribute apportionable receipts.

Example 34. One office of ZYX LLC has information that can easily be used to determine a reasonable proportional attribution of receipts, but does not provide this information to the office preparing the tax returns. ZYX LLC must use the information maintained by the marketing office to attribute its receipts.

Example 35. CBA, Inc. is entitled to receive information from an affiliate or unrelated third party which it could use to determine where the benefit of its services is received but chooses not to obtain that information. CBA, Inc. must use the information maintained by the affiliate or unrelated third party to attribute its apportionable receipts.

Example 36. Same facts as Example 35, except that the information is raw data that must be formatted and otherwise processed at a cost that exceeds the total amount of tax CBA, Inc. would owe if it paid tax on all of its world-wide income. In this case, it is not commercially reasonable for CBA, Inc. to use this data to determine where to attribute its income.

PART 4. RECEIPTS FACTOR.

(401) **General.** The receipts factor is a fraction that applies to apportionable income for each calendar year. Taxpayers must calculate a separate receipts factor for each apportionable activity (business and occupation tax classification) engaged in.

(402) **Receipts factor calculation.** The receipts factor is: Washington attributed apportionable receipts divided by world-wide apportionable receipts less throw-out income (see subsection (403) of this section). The receipts factor expressed algebraically is:

$$\text{(Receipts factor)} = \frac{\text{(Washington apportionable receipts)}}{\text{((World-wide apportionable receipts) - (Throw-out income))}}$$

(a) The numerator of the receipts factor is: The total apportionable receipts attributable to Washington during the calendar year from engaging in the apportionable activity.

(b) The denominator of the receipts factor is: The total (world-wide, including Washington) apportionable receipts from engaging in the apportionable activity during the calendar year, less throw-out income.

Example 37. NOP, Inc. has $400,000 of receipts attributed to Washington and $1,000,000 of world-wide receipts. Assuming that there is no throw-out income, NOP's receipts factor is 40% (400,000/1,000,000).

(c) In the very rare situation where the receipts factor (after reducing the denominator by the throw-out income) is zero divided by zero, the receipts factor is deemed to be zero.

(403) **Throw-out income.** Throw-out income includes all apportionable receipts attributed to states where the taxpayer:

(a) Is not taxable (see subsection (107) of this rule); and

(b) At least part of the activity of the taxpayer related to the throw-out income is performed in Washington.

Example 38. XYZ Corp. performs all services in Washington and has apportionable receipts attributed using the criteria listed in subsections (301) through (304) of this rule or WAC 458-20-19403 as follows: Washington $500,000; Idaho $200,000; Oregon $100,000; and California $300,000. XYZ Corp. is subject to Oregon and Idaho corporate income tax, but does not owe any California business activities taxes. XYZ does not have any throw-out income because Oregon and Idaho impose a business activities tax on its activities and it is deemed to be taxable in California because it satisfies the minimum nexus standards explained in WAC 458-20-19401 (more than $250,000 in receipts). XYZ's receipts factor is: 500,000/1,100,000 or 45.45%.

Example 39. Same facts as Example 38 except Idaho does not impose any tax on XYZ Corp. The $200,000 attributed to Idaho is throw-out income that is excluded from the denominator because: XYZ Corp. is not subject to Idaho business activities taxes; does not have substantial nexus with Idaho under Washington standards; and performs in Washington at least part of the activities related to the receipts attributed to Idaho. The receipts factor is 500,000/900,000 or 55.56%.

Example 40. The same facts as Example 39 except XYZ Corp. performs no activities in Washington related to the $200,000 attributed to Idaho. In this situation, the $200,000 is not throw-out income and remains in the denominator. The receipts factor is: 500,000/1,100,000 or 45.45%.

PART 5. HOW TO DETERMINE WASHINGTON TAXABLE INCOME.

(501) **General.** Washington taxable income is determined by multiplying apportionable income by the receipts factor for each apportionable activity the taxpayer engages in. While the receipts factor is calculated without regard to deductions authorized under chapter 82.04 RCW, apportionable income is determined by reducing the apportionable receipts by amounts that are deductible under chapter 82.04 RCW regardless of where the deduction may be attributed. This formula can be expressed algebraically as:

(Taxable Income) = (Receipts Factor) x (Apportionable receipts - deductions)

Example 41. Calculating apportionable income. Corporation A received $2,000,000 in apportionable receipts from its world-wide apportionable activities, which included $500,000 of receipts that are deductible under Washington law. Corporation A's total apportionable income is $1,500,000 ($2,000,000 minus $500,000 of deductions). If Corporation A's receipts factor is 31.25%, then its taxable income is $468,750 ($1,500,000 multiplied by 0.3125).

PART 6. REPORTING INSTRUCTIONS.

(601) **General.**

(a) Taxpayers required to use this rule's apportionment method may report their taxable income based on their apportionable income for the reporting period multiplied by the receipts factor for the most recent calendar year the taxpayer has available.

(b) If a taxpayer does not calculate its taxable income using (a) of this subsection, the taxpayer must use actual current calendar year information.

(602) **Reconciliation.** Regardless of how a taxpayer reports its taxable income under subsection (601)(a) or (b) of this rule, when the taxpayer has the information to determine the receipts factor for an entire calendar year, it must file a reconciliation and either obtain a refund or pay any additional tax due. The reconciliation must be filed on a form approved by the department. In either event (refund or additional taxes due), interest will apply in a manner consistent with tax assessments. If the reconciliation is completed prior to October 31st of the following year, no penalties will apply to any additional tax that may be due.

NEW SECTION

WAC 458-20-19403 Apportionable royalty receipts attribution.

PART 1. INTRODUCTION.

(101) **General.** Effective June 1, 2010, Washington changed its method of apportioning royalty receipts. This rule only addresses how apportionable royalty receipts must be attributed for the purposes of economic nexus and single factor receipts apportionment. This rule is limited to the attribution of apportionable royalty receipts for periods after May 31, 2010.

(102) **Guide to this rule.** This rule is divided into two parts as follows:

1. Introduction.

2. How to attribute apportionable royalty receipts.

(103) **Reference to WAC 458-20-19402.** This rule only provides a method to attribute apportionable royalty receipts in lieu of the attribution methods specified in WAC 458-20-19402 (301)(a) and (b). Otherwise, WAC 458-20-19402 controls the apportionment of royalty receipts. Specifically, WAC 458-20-19402 provides: (a) An overview of single factor receipts apportionment (Part 2); (b) guidance on how to attribute apportionable royalty receipts if this rule does not apply (Part 3); (c) guidance on how to calculate the receipts factor (Part 4); (d) guidance on how to determine taxable income (Part 5); and (e) reporting instructions (Part 6).

(104) **Other rules.** Taxpayers may also find helpful information in the following rules:

(a) WAC 458-20-19401 **Minimum nexus thresholds for apportionable activities.** This rule describes minimum nexus thresholds applicable to apportionable activities that are effective after May 31, 2010.

(b) WAC 458-20-19402 **Single factor receipts apportionment—Generally.** This rule describes the general application of single factor receipts apportionment and applies only to tax liability incurred after May 31, 2010.

(c) WAC 458-20-19404 **Single factor receipts apportionment—Financial institutions.** This rule describes the application of single factor receipts apportionment to certain income of financial institutions and applies only to tax liability incurred after May 31, 2010.

(d) WAC 458-20-194 **Doing business inside and outside the state.** This rule describes separate accounting and cost apportionment and applies only to tax liability incurred from January 1, 2006, through May 31, 2010.

(e) WAC 458-20-14601 **Financial institutions—Income apportionment.** This rule describes the apportionment of income for financial institutions for tax liability incurred prior to June 1, 2010.

(105) **Examples.** Examples included in this rule identify a number of facts and then state a conclusion; they should be used only as a general guide. The tax results of all situations must be determined after a review of all the facts and circumstances. The examples in this rule assume all gross income received by the taxpayer is apportionable royalty receipts. Unless otherwise stated, the examples do not apply to tax liability prior to June 1, 2010.

(106) **Definitions.** The definitions included in WAC 458-20-19401 and 458-20-19402 apply to this rule unless the context clearly requires otherwise. Additionally, the definitions in this subsection apply specifically to this rule.

(a) **"Apportionable royalty receipts"** means all compensation for the use of intangible property, including charges in the nature of royalties, regardless of where the intangible property will be used. Apportionable royalty receipts does not include:

(i) Compensation for any natural resources;

(ii) The licensing of prewritten computer software to an end user;

(iii) The licensing of digital goods, digital codes, or digital automated services to an end user as defined in RCW 82.04.190(11); or

(iv) Receipts from the outright sale of intangible property.

(b) **"Intangible property"** includes: Copyrights, patents, licenses, franchises, trademarks, trade names, and other similar intangible property/rights.

(c) **"Reasonable method of proportionally attributing"** means a method of determining where the use occurs, and thus where receipts are attributed that is uniform, consistent, accurately reflects the market, and is not distortive.

PART 2. HOW TO ATTRIBUTE APPORTIONABLE ROYALTY RECEIPTS.

(201) **Attribution of income.** Apportionable royalty receipts are attributed to states based on a cascading method or series of steps. The department expects that most taxpayers will attribute apportionable royalty receipts based on (a)(i) of this subsection because the department believes that either taxpayers will know the place of use or a "reasonable method of proportionally attributing" receipts will generally be available. These steps are:

(a) **Where the customer uses the intangible property.**

(i) If a taxpayer can reasonably determine the amount of a specific apportionable royalty receipt that relates to a specific use in a state, that royalty receipt is attributable to that state. This may be shown by application of a reasonable method of proportionally attributing use, and thus receipts, among the states. The result determines the apportionable royalty receipts attributed to each state. Under certain situations, the use of data based on an attribution method specified in (b) and (c) of this subsection may also be a reasonable method of proportionally attributing receipts among states.

(ii) If a taxpayer is unable to separately determine, or use a reasonable method of proportionally attributing, the use and receipts in specific states under (a)(i) of this subsection, and the customer used the intangible property in multiple states, the apportionable royalty receipts are attributed to the state in which the intangible property was primarily used. Primarily means, in this case, more than fifty percent.

(b) **Office of negotiation.** If the taxpayer is unable to attribute apportionable royalty receipts to a location under (a) of this subsection, then apportionable royalty receipts must be attributed to the office of the customer from which the royalty agreement with the taxpayer was negotiated.

(c) If the taxpayer is unable to attribute apportionable royalty receipts to a location under (a) and (b) of this subsection, then the steps specified in WAC 458-20-19402 (301)(c) through (g) shall apply to apportionable royalty receipts.

(202) **Framework for analysis of the "use of intangible property."** The use of intangible property and therefore the attribution of apportionable royalty receipts from the use of intangible property will generally fall into one of the following three categories:

(a) **Marketing use** means the intangible property is used by the taxpayer's customer for purposes that include, but are not limited to, marketing, displaying, selling, and exhibiting. The use of the intangible property is connected to the sale of goods or services. Typically, this category includes trademarks, copyrights, trade names, logos, or other intangibles with promotional value. Receipts from the marketing use of intangible property are generally attributed to the location of the consumer of the goods or services promoted using the intangible property.

Example 1. SportsCo licenses to AthleticCo the right to use its trademark on a basketball that AthleticCo manufactures, markets, and sells at retail on its web site. This is a marketing use. SportsCo is paid a fee based on AthleticCo's basketball sales in multiple states. SportsCo knows that sales from the AthleticCo web site delivered to Washington represent 10% of AthleticCo's total sales. Pursuant to subsection (201)(a)(i) of this section, SportsCo will attribute 10% of its apportionable royalty receipts received from AthleticCo to Washington. The remaining 90% will be attributed to other states.

Example 2. Same facts as Example 1, except that AthleticCo sells its basketballs at wholesale to MiddleCo, a distributor with its receiving warehouse located in Idaho. MiddleCo then sells the basketballs to RetailW, a retailer with stores in Washington, Oregon, and California. SportsCo would generally attribute its apportionable royalty receipts to the location of RetailW's customers. However, SportsCo does not have any data, and cannot reasonably obtain any data, relating to RetailW's customer locations. Pursuant to subsection (201)(a)(i) of this section, SportsCo may reasonably attribute receipts to Washington based on the percentage of RetailW's store locations in Washington as long as such attribution does not distort the number of customers in each state. SportsCo knows that 15% of RetailW's store locations are in Washington therefore it is reasonable for SportsCo to attribute 15% of its apportionable royalty receipts to Washington. The remaining 85% will be attributed to other states.

Example 3. MusicCo licenses to RetailCo the right to make copies of a digital song and sell those copies at retail on the internet for the U.S. market only. This is a marketing use. RetailCo has a single copy of the song on its server in Virginia. Each time a customer comes to RetailCo's web site and makes a purchase of the song, RetailCo creates a copy of the song (e.g., a new file) that is then available for sale to the customer. MusicCo would usually attribute its apportionable royalty receipts to the location of RetailCo's customers. However, MusicCo does not have any data, and cannot reasonably obtain any specific data, relating to RetailCo's customers' locations. Pursuant to subsection (201)(a)(i) of this section, MusicCo may reasonably attribute receipts to each state based on the percentage that each state's population represents in relation to the total market population, which in this case is the U.S. population, as long as such attribution does not distort the number of customers in each state.

Example 4. A local baseball star, Joe Ball, plays for a professional athletic franchise located in Washington. Joe Ball licenses to T-ShirtCo the right to put his image on t-shirts and sell them on the internet in the U.S. market. This is a marketing use limited to the U.S. by license. Joe Ball does not know where T-ShirtCo's customers are located and cannot reasonably obtain data to reasonably attribute receipts. In the absence of actual sales data from T-ShirtCo, Joe Ball cannot use relative population data to attribute receipts to the states as was done in Example 3 above. This is because Joe Ball is an overwhelmingly "local" celebrity in Washington. Joe Ball does not have a "national appeal" such that t-shirt sales by T-ShirtCo would be significant outside Washington. In this case, Joe Ball is unable to separately determine the use of the intangible property in specific states pursuant to subsection (201)(a)(i) of this section. However, it is reasonable for Joe Ball to assume that sales by T-ShirtCo of Joe Ball shirts are primarily delivered to customers in Washington. Accordingly, Joe Ball should assign all receipts received from T-ShirtCo to Washington, pursuant to subsection (201)(a)(ii) of this section.

Example 5. MegaComputer ("Mega") manufactures and sells computers. SoftwareCo licenses to MegaComputer

the right to copy and install the software on Mega's computers, which are then offered for sale to consumers. This is a marketing use by Mega. Mega sells its computers to DistributorX that in turn sells the computers to RetailerY. Mega uses the intangible property at the location of the consumer. If SoftwareCo can attribute its receipts to the location of the consumer (e.g., through the use of software registration data obtained from consumer), SoftwareCo should do so. In the absence of that more precise information, and pursuant to subsection (201)(a)(i) of this section, it would be "reasonable" for SoftwareCo to attribute its receipts in proportion to the number of RetailerY stores in each state.

(b) **Nonmarketing use** means the intangible property is used for purposes other than marketing, displaying, selling, and exhibiting. This use of the intangible property is often connected to manufacturing, research and development, or other similar nonmarketing uses. Typically, this category includes patents, know-how, designs, processes, models, and similar intangibles. Receipts from the nonmarketing use of intangible property are generally attributed to a specific location or locations where the manufacturing, research and development, or other similar nonmarketing use occurs.

Example 6. RideCo licenses the right to use its patented scooter brake to FunRide for the purpose of manufacturing scooters. FunRide will market the scooter under its own brand. This is a nonmarketing use. RideCo knows that FunRide will manufacture scooters in Michigan and Washington and that the scooter design is used equally in Michigan and Washington. Pursuant to subsection (201)(a)(i) of this section, RideCo will attribute its receipts from the license of its patent equally to Michigan and Washington.

Example 7. BurgerZ licenses to JoeHam the right to use its jumbo hamburger making process and know-how. This is a nonmarketing use. JoeHam markets the jumbo hamburgers under its own brand. JoeHam has two restaurant locations, one in Washington and one in Oregon. BurgerZ's fee for the intangible rights is based on a percentage of sales at each location. Pursuant to subsection (201)(a)(i) of this section, BurgerZ will attribute receipts from its license with JoeHam to each location based on sales at those locations.

Example 8. WidgetCo licenses the use of its patent to ManuCo, to manufacture widgets. ManuCo has three manufacturing plants located in Michigan where it will use the patent for manufacturing widgets. ManuCo also has a single research and development (R&D) facility in Washington where it will use the patented technology to develop the next generation of its widgets. These are nonmarketing uses. WidgetCo charges ManuCo a single price for the use of the patent in manufacturing and R&D. In the absence of information to the contrary, it is reasonable for WidgetCo to assume ManuCo's use of the patent is equal at all of ManuCo's relevant locations. Pursuant to subsection (201)(a)(i) of this section, because there are four locations where the patent is used equally, WidgetCo will attribute 25% of its apportionable royalty receipts to each of the four locations. Accordingly, 75% of the apportionable royalty receipts will be attributed to Michigan to reflect the use of the patent at the three manufacturing locations, and 25% of the apportionable royalty receipts will be attributable to Washington to reflect the use of the patent at the single R&D location.

(c) **Mixed use** means licensing the use of intangible property for both marketing and nonmarketing uses. Mixed use licenses may be sold for a single fee or more than one fee.

(i) **Single fee.** Where a single fee is charged for the mixed use license, it will be presumed that receipts were earned for a "marketing use" pursuant to the guidelines provided in (a) of this subsection, except to the extent that the taxpayer can reasonably establish otherwise or the department of revenue determines otherwise.

Example 9. ProcessCo licenses to KimchiCo, for a single fee, the right to use its patent and trademark for manufacturing and marketing a food processing device. KimchiCo has a single manufacturing plant in Washington and markets the finished product solely in Korea. This mixed use license for a single fee is presumed to be for a marketing use. Accordingly, ProcessCo must attribute receipts under the guidelines established for marketing uses. Pursuant to subsection (201)(a)(i) of this section, KimchiCo is marketing and selling the device only in Korea; therefore, all receipts will be attributed to Korea.

Example 10. FranchiseCo operates a restaurant franchising business and licenses the right to use its trademark, patent, and know-how to EatQuick for a single fee. EatQuick will use the intangibles to create and market its food product. This is a mixed use license for a single fee and will be presumed to be for a marketing use. EatQuick has a single restaurant location in Washington, where all sales are made. Pursuant to subsection (201)(a)(i) of this section, the intangible property is used by EatQuick in Washington at its restaurant location. Taxpayer will attribute 100% of its apportionable royalty receipts earned under the EatQuick license to Washington.

Example 11. Same facts as Example 10, except that EatQuick has five restaurant locations, one each in: Washington, California, Oregon, Idaho, and Montana. EatQuick pays an annual lump sum to FoodCo. This is a mixed use license for a single fee and will be presumed to be for marketing use. Further, FranchiseCo knows that EatQuick's use of the intangible property is equal at all locations. The intangible property is used equally by EatQuick in five states including Washington. Accordingly, pursuant to subsection (201)(a)(i) of this section, FoodCo will attribute 20% of its apportionable royalty receipts to each location, including Washington.

(ii) **More than one fee.** Where the mixed use license involves separate fees for each type of use and separate itemization is reasonable, then each fee will receive separate attribution treatment pursuant to (a) and (b) of this subsection. If the department determines that the separate itemization is not reasonable, the department may provide for more accurate attribution using the guidelines in (a) and (b) of this subsection.

Example 12. Same as Example 9, except the license agreement states that the nonmarketing use of the patent is valued at $450,000, and the marketing use of the trademark is valued at $550,000. This is a mixed use license with more than one fee. The stated values for the separate uses are reasonable. Pursuant to subsection (201)(a)(i) of this section, the receipts associated with the nonmarketing use are $450,000 and attributable to Washington where the patent is

used in manufacturing. The receipts associated with the marketing use are $550,000 and attributed to Korea where the trademark is used for marketing and selling the finished product.

WSR 12-06-081
PROPOSED RULES
DEPARTMENT OF REVENUE
[Filed March 7, 2012, 12:00 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 10-12-128.

Title of Rule and Other Identifying Information: WAC 458-20-19404 (Rule 19404) Financial institutions—Income apportionment.

Hearing Location(s): Capital Plaza Building, 4th Floor Executive Conference Room, 1025 Union Avenue S.E., Olympia, WA 98504, on April 19, 2012, at 9:00 a.m. Copies of draft rules are available for viewing and printing on our web site at Rules Agenda.

Date of Intended Adoption: April 27, 2012.

Submit Written Comments to: Chris Coffman, e-mail ChrisC@dor.wa.gov, P.O. Box 47453, Olympia, WA 98504-7453, by April 19, 2012.

Assistance for Persons with Disabilities: Contact Mary Carol LaPalm, (360) 725-7499, or Renee Cosare, (360) 725-7514, no later than ten days before the hearing date. For hearing impaired please contact us via the Washington relay operator at (800) 833-6384.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Effective June 1, 2010, chapter 23, Laws of 2010 1st sp. sess., changed Washington's method of apportioning certain gross income from engaging in business as a financial institution. The department is proposing a new Rule 19404 to address how such gross income must be apportioned when a financial institution engages in business both within and outside the state.

Reasons Supporting Proposal: This rule is needed to recognize law changes.

Statutory Authority for Adoption: RCW 82.32.300 and 82.01.060.

Statute Being Implemented: Provisions of chapter 23, Laws of 2010 1st sp. sess. (2ESSB 6143) Part I.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of revenue, governmental.

Name of Agency Personnel Responsible for Drafting: Chris Coffman, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1590; Implementation: Alan R. Lynn, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1599; and Enforcement: Russ Brubaker, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1505.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This rule does not impose any new performance requirements or administrative burden on any small business not required by statute.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Chris Coffman, P.O. Box 47453, Olympia, WA 98504-7453, phone (360) 534-1590, e-mail ChrisC@dor.wa.gov.

March 7, 2012
Alan R. Lynn
Rules Coordinator

NEW SECTION

WAC 458-20-19404 Financial institutions—Income apportionment. (1) **Introduction.**

(a) Effective June 1, 2010, section 108, chapter 23, Laws of 2010 1st sp. sess. changed Washington's method of apportioning certain gross income from engaging in business as a financial institution. This rule addresses how such gross income must be apportioned when the financial institution engages in business both within and outside the state.

(b) Taxpayers may also find helpful information in the following rules:

(i) WAC 458-20-19401, Minimum nexus thresholds for apportionable activities. This rule describes minimum nexus standards that are effective after May 31, 2010.

(ii) WAC 458-20-19402, Single factor receipts apportionment—Generally. This rule describes the general application of single factor receipts apportionment that is effective after May 31, 2010.

(iii) WAC 458-20-19403, Single factor receipts apportionment—Royalties. This rule describes the application of single factor receipts apportionment to gross income from royalties and applies only to tax liability incurred after May 31, 2010.

(iv) WAC 458-20-194, Doing business inside and outside the state. This rule describes separate accounting and cost apportionment. It applies only to the periods January 1, 2006, through May 31, 2010.

(v) WAC 458-20-14601, Financial institutions—Income apportionment. This rule describes the apportionment of income for financial institutions for periods prior to June 1, 2010.

(c) Financial institutions engaged in making interstate sales of tangible personal property should also refer to WAC 458-20-193, Inbound and outbound interstate sales of tangible personal property.

(2) **Apportionment and allocation.**

(a) Except as otherwise specifically provided, a financial institution taxable under RCW 82.04.290 and taxable in another state must attribute and apportion its service and other activities income as provided in this rule. Any other apportionable income must be apportioned pursuant to WAC 458-20-19402, Single factor receipts apportionment—Generally or WAC 458-20-19403, Single factor receipts apportionment—Royalties. "Apportionable income" means gross income of the business generated from engaging in apportionable activities as defined in WAC 458-20-19401, Minimum nexus thresholds for apportionable activities, including income received from apportionable activities performed outside this state if the income would be taxable under chapter 82.04 RCW if received from activities in this state, less

any deductions allowable under chapter 82.04 RCW. All gross income that is not includable from apportionable activities must be allocated pursuant to chapter 82.04 RCW. A financial institution organized under the laws of a foreign country, the Commonwealth of Puerto Rico, or a territory or possession of the United States, except such institutions that are exempt under RCW 82.04.315, whose effectively connected income (as defined under the federal Internal Revenue Code) is taxable both in this state and another state, other than the state in which it is organized, must allocate and apportion its gross income as provided in this rule.

(b) The apportionment percentage is determined by the taxpayer's receipts factor (as described in subsection (4) of this rule).

(c) The receipts factor must be computed according to the method of accounting (cash or accrual basis) used by the taxpayer for Washington state tax purposes for the taxable period. Persons should refer to WAC 458-20-197, When tax liability arises and WAC 458-20-199, Accounting methods for further guidance on the requirements of each accounting method. Generally, financial institutions are required to file returns on a monthly basis. To enable financial institutions to more easily comply with this rule, financial institutions may file returns using the receipts factor calculated based on the most recent calendar year for which information is available. If a financial institution does not calculate its receipts factor based on the previous calendar year for which information is available, it must use the current year information to make that calculation. In either event, a reconciliation must be filed for each year not later than October 31st of the following year. The reconciliation must be filed on a form approved by the department. In the case of consolidations, mergers, or divestitures, a taxpayer must make the appropriate adjustments to the factors to reflect its changed operations.

(d) Interest and penalties on reconciliations under (c) of this subsection apply as follows:

(i) In either event (refund or additional taxes due), interest will apply in a manner consistent with tax assessments.

(ii) Penalties as provided in RCW 82.32.090 will apply to any such additional tax due only if the reconciliation for a tax year is not completed and additional tax is not paid by October 31st of the following year.

(e) If the allocation and apportionment provisions of this rule do not fairly represent the extent of its business activity in this state, the taxpayer may petition for, or the department may require, in respect to all or any part of the taxpayer's business activity:

(i) Separate accounting;

(ii) The inclusion of one or more additional factors which will fairly represent the taxpayer's business activity in this state; or

(iii) The employment of any other method to effectuate an equitable allocation and apportionment of the taxpayer's receipts.

(3) **Definitions.** The following definitions apply throughout this rule unless the context clearly requires otherwise:

(a) **"Billing address"** means the location indicated in the books and records of the taxpayer on the first day of the taxable period (or on such later date in the taxable period when the customer relationship began) as the address where any notice, statement and/or bill relating to a customer's account is mailed.

(b) **"Borrower or credit card holder located in this state"** means:

(i) A borrower, other than a credit card holder, that is engaged in a trade or business and maintains its commercial domicile in this state; or

(ii) A borrower that is not engaged in a trade or business or a credit card holder, whose billing address is in this state.

(c) **"Commercial domicile"** means:

(i) The headquarters of the trade or business, that is, the place from which the trade or business is principally managed and directed; or

(ii) If a taxpayer is organized under the laws of a foreign country, or of the Commonwealth of Puerto Rico, or any territory or possession of the United States, such taxpayer's commercial domicile is deemed for the purposes of this rule to be the state of the United States or the District of Columbia from which such taxpayer's trade or business in the United States is principally managed and directed. It is presumed, subject to rebuttal by a preponderance of the evidence, that the location from which the taxpayer's trade or business is principally managed and directed is the state of the United States or the District of Columbia to which the greatest number of employees are regularly connected or out of which they are working, irrespective of where the services of such employees are performed, as of the last day of the taxable period.

(d) **"Credit card"** means credit, travel or entertainment card.

(e) **"Credit card issuer's reimbursement fee"** means the fee a taxpayer receives from a merchant's bank because one of the persons to whom the taxpayer has issued a credit card has charged merchandise or services to the credit card.

(f) **"Department"** means the department of revenue.

(g) **"Employee"** means, with respect to a particular taxpayer, any individual who, under the usual common-law rules applicable in determining the employer-employee relationship, has the status of an employee of that taxpayer.

(h) **"Financial institution"** means:

(i) Any corporation or other business entity chartered under Title 30, 31, 32, or 33 RCW, or registered under the Federal Bank Holding Company Act of 1956, as amended, or registered as a savings and loan holding company under the Federal National Housing Act, as amended;

(ii) A national bank organized and existing as a national bank association pursuant to the provisions of the National Bank Act, 12 U.S.C. Sec. 21 et seq.;

(iii) A savings association or federal savings bank as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1813(b)(1);

(iv) Any bank or thrift institution incorporated or organized under the laws of any state;

(v) Any corporation organized under the provisions of 12 U.S.C. Secs. 611 to 631;

(vi) Any agency or branch of a foreign depository as defined in 12 U.S.C. Sec. 3101 that is not exempt under RCW 82.04.315;

(vii) Any credit union, other than a state or federal credit union exempt under state or federal law;

(viii) A production credit association organized under the Federal Farm Credit Act of 1933, all of whose stock held by the Federal Production Credit Corporation has been retired.

(i) **"Gross income of the business," "gross income,"** or **"income"**:

(i) Has the same meaning as in RCW 82.04.080 and means the value proceeding or accruing by reason of the transaction of the business engaged in and includes compensation for the rendition of services, gains realized from trading in stocks, bonds, or other evidences of indebtedness, interest, discount, rents, royalties, fees, commissions, dividends, and other emoluments however designated, all without any deduction on account of the cost of tangible property sold, the cost of materials used, labor costs, interest, discount, delivery costs, taxes, or any other expense whatsoever paid or accrued and without any deduction on account of losses; and

(ii) Does not include amounts received from an affiliated person if those amounts are required to be determined at arm's length per sections 23A or 23B of the Federal Reserve Act. For the purpose of (3)(i) of this subsection, affiliated means the affiliated person and the financial institution are under common control. Control means the possession (directly or indirectly), of more than fifty percent of power to direct or cause the direction of the management and policies of each entity. Control may be through voting shares, contract, or otherwise.

(iii) Financial institutions must determine their gross income of the business from gains realized from trading in stocks, bonds, and other evidences of indebtedness on a net annualized basis.

(j) **"Loan"** means any extension of credit resulting from direct negotiations between the taxpayer and its customer, and/or the purchase, in whole or in part, of such extension of credit from another. Loan includes participations, syndications, and leases treated as loans for federal income tax purposes. Loan does not include: Futures or forward contracts; options; notional principal contracts such as swaps; credit card receivables, including purchased credit card relationships; noninterest bearing balances due from depository institutions; cash items in the process of collection; federal funds sold; securities purchased under agreements to resell; assets held in a trading account; securities; interests in a real estate mortgage investment conduit (REMIC), or other mortgage-backed or asset-backed security; and other similar items.

(k) **"Loan secured by real property"** means that fifty percent or more of the aggregate value of the collateral used to secure a loan or other obligation was real property, when valued at fair market value as of the time the original loan or obligation was incurred.

(l) **"Merchant discount"** means the fee (or negotiated discount) charged to a merchant by the taxpayer for the privilege of participating in a program whereby a credit card is accepted in payment for merchandise or services sold to the card holder.

(m) **"Participation"** means an extension of credit in which an undivided ownership interest is held on a *pro rata* basis in a single loan or pool of loans and related collateral. In a loan participation, the credit originator initially makes the loan and then subsequently resells all or a portion of it to other lenders. The participation may or may not be known to the borrower.

(n) **"Person"** has the meaning given in RCW 82.04.030.

(o) **"Regular place of business"** means an office at which the taxpayer carries on its business in a regular and systematic manner and which is continuously maintained, occupied and used by employees of the taxpayer.

(p) **"Service and other activities income"** means the gross income of the business taxable under RCW 82.04.290, including income received from activities outside this state if the income would be taxable under RCW 82.04.290 if received from activities in this state, less the exemptions and deductions allowable under chapter 82.04 RCW.

(q) **"State"** means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any foreign country or political subdivision of a foreign country.

(r) **"Syndication"** means an extension of credit in which two or more persons fund and each person is at risk only up to a specified percentage of the total extension of credit or up to a specified dollar amount.

(s) **"Taxable in another state"** means either:

(i) The taxpayer is subject to business activities tax by another state on its service and other activities income; or

(ii) The taxpayer is not subject to a business activities tax by another state on its service and other activities income, but that state has jurisdiction to subject the taxpayer to a business activities tax on such income under the substantial nexus standards explained in WAC 458-20-19401. For purposes of (s) of this subsection, "business activities tax" means a tax measured by the amount of, or economic results of, business activity conducted in a state. The term includes taxes measured in whole or in part on net income or gross income or receipts. Business activities tax does not include a sales tax, use tax, or a similar transaction tax, imposed on the sale or acquisition of goods or services, whether or not denominated a gross receipts tax or a tax imposed on the privilege of doing business.

(t) **"Taxable period"** means the calendar year during which tax liability is incurred.

(4) **Receipts factor.**

(a) General. The receipts factor is a fraction, the numerator of which is the apportionable income of the taxpayer in this state during the taxable period and the denominator of which is the apportionable income of the taxpayer inside and outside this state during the taxable period. The method of calculating receipts for purposes of the denominator is the same as the method used in determining receipts for purposes of the numerator.

(b) Interest from loans secured by real property.

(i) The numerator of the receipts factor includes interest and fees or penalties in the nature of interest from loans secured by real property if the property is located within this state. If the property is located both within this state and one or more other states, the income described in this subsection (b)(i) is included in the numerator of the receipts factor if more than fifty percent of the fair market value of the real property is located within this state. If more than fifty percent

of the fair market value of the real property is not located within any one state, then the income described in this subsection (b)(i) must be included in the numerator of the receipts factor if the borrower is located in this state.

(ii) The determination of whether the real property securing a loan is located within this state must be made as of the time the original agreement was made and any and all subsequent substitutions of collateral must be disregarded.

(c) Interest from loans not secured by real property. The numerator of the receipts factor includes interest and fees or penalties in the nature of interest from loans not secured by real property if the borrower is located in this state. Interest and fees on loans secured by commercial aircraft that qualifies for the exemption from business and occupation tax under RCW 82.04.43391 are not included in either numerator or the denominator of the receipts factor.

(d) Net gains from the sale of loans. The numerator of the receipts factor includes net gains from the sale of loans. Net gains from the sale of loans includes income recorded under the coupon stripping rules of Section 1286 of the federal Internal Revenue Code.

(i) The amount of net gains (but not less than zero) from the sale of loans secured by real property included in the numerator is determined by multiplying such net gains by a fraction, the numerator of which is the amount included in the numerator of the receipts factor pursuant to (b) of this subsection and the denominator of which is the total amount of interest and fees or penalties in the nature of interest from loans secured by real property.

(ii) The amount of net gains (but not less than zero) from the sale of loans not secured by real property included in the numerator is determined by multiplying such net gains by a fraction, the numerator of which is the amount included in the numerator of the receipts factor pursuant to (c) of this subsection (4) and the denominator of which is the total amount of interest and fees or penalties in the nature of interest from loans not secured by real property.

(e) Receipts from credit card receivables. The numerator of the receipts factor includes interest and fees or penalties in the nature of interest from credit card receivables and income from fees charged to card holders, such as annual fees, if the billing address of the card holder is in this state.

(f) Net gains from the sale of credit card receivables. The numerator of the receipts factor includes net gains (but not less than zero) from the sale of credit card receivables multiplied by a fraction, the numerator of which is the amount included in the numerator of the receipts factor pursuant to (e) of this subsection and the denominator of which is the taxpayer's total amount of interest and fees or penalties in the nature of interest from credit card receivables and fees charged to card holders.

(g) Credit card issuer's reimbursement fees. The numerator of the receipts factor includes all credit card issuer's reimbursement fees multiplied by a fraction, the numerator of which is the amount included in the numerator of the receipts factor pursuant to (e) of this subsection and the denominator of which is the taxpayer's total amount of interest and fees or penalties in the nature of interest from credit card receivables and fees charged to card holders.

(h) Receipts from merchant discount. The numerator of the receipts factor includes receipts from merchant discount if the commercial domicile of the merchant is in this state. Such receipts must be computed net of any cardholder charge backs, but must not be reduced by any interchange transaction fees or by any issuer's reimbursement fees paid to another for charges made by its card holders.

(i) Loan servicing fees.

(i)(A) The numerator of the receipts factor includes loan servicing fees derived from loans secured by real property multiplied by a fraction, the numerator of which is the amount included in the numerator of the receipts factor under (b) of this subsection and the denominator of which is the total amount of interest and fees or penalties in the nature of interest from loans secured by real property.

(B) The numerator of the receipts factor includes loan servicing fees derived from loans not secured by real property multiplied by a fraction, the numerator of which is the amount included in the numerator of the receipts factor under (c) of this subsection and the denominator of which is the total amount of interest and fees or penalties in the nature of interest from loans not secured by real property.

(ii) If the taxpayer receives loan servicing fees for servicing either the secured or the unsecured loans of another, the numerator of the receipts factor includes such fees if the borrower is located in this state.

(j) Receipts from services. The numerator of the receipts factor includes receipts from services not otherwise apportioned under this subsection (4) if the service is performed in this state. If the service is performed both inside and outside this state, the numerator of the receipts factor includes receipts from services not otherwise apportioned under this subsection (4), if a greater proportion of the activity producing the receipts is performed in this state based on cost of performance.

(k) Receipts from investment assets and activities and trading assets and activities.

(i) Interest, dividends, net gains (but not less than zero) and other income from investment assets and activities and from trading assets and activities are included in the receipts factor. Investment assets and activities and trading assets and activities include, but are not limited to: Investment securities; trading account assets; federal funds; securities purchased and sold under agreements to resell or repurchase; options; futures contracts; forward contracts; notional principal contracts such as swaps; equities; and foreign currency transactions. With respect to the investment and trading assets and activities described in (k)(i)(A) and (B) of this subsection, the receipts factor includes the following:

(A) The receipts factor includes the amount by which interest from federal funds sold and securities purchased under resale agreements exceeds interest expense on federal funds purchased and securities sold under repurchase agreements.

(B) The receipts factor includes the amount by which interest, dividends, gains and other receipts from trading assets and activities including, but not limited to, assets and activities in the matched book, in the arbitrage book, and foreign currency transactions, exceed amounts paid in lieu of

interest, amounts paid in lieu of dividends, and losses from such assets and activities.

(ii) The numerator of the receipts factor includes interest, dividends, net gains (but not less than zero) and other receipts from investment assets and activities and from trading assets and activities described in (k)(i) of this subsection that are attributable to this state.

(A) The amount of interest, dividends, net gains (but not less than zero) and other income from investment assets and activities in the investment account to be attributed to this state and included in the numerator is determined by multiplying all such income from such assets and activities by a fraction, the numerator of which is the average value of such assets which are properly assigned to a regular place of business of the taxpayer within this state and the denominator of which is the average value of all such assets.

(B) The amount of interest from federal funds sold and purchased and from securities purchased under resale agreements and securities sold under repurchase agreements attributable to this state and included in the numerator is determined by multiplying the amount described in (k)(i)(A) of this subsection from such funds and such securities by a fraction, the numerator of which is the average value of federal funds sold and securities purchased under agreements to resell which are properly assigned to a regular place of business of the taxpayer within this state and the denominator of which is the average value of all such funds and such securities.

(C) The amount of interest, dividends, gains and other income from trading assets and activities including, but not limited to, assets and activities in the matched book, in the arbitrage book and foreign currency transactions (but excluding amounts described in (k)(i)(A) and (B) of this subsection), attributable to this state and included in the numerator is determined by multiplying the amount described in (k)(i)(B) of this subsection by a fraction, the numerator of which is the average value of such trading assets which are properly assigned to a regular place of business of the taxpayer within this state and the denominator of which is the average value of all such assets.

(D) For purposes of (k)(ii) of this subsection, the average value of trading assets owned by the taxpayer is the original cost or other basis of such property for federal income tax purposes without regard to depletion, depreciation, or amortization.

(iii) In lieu of using the method set forth in (k)(ii) of this subsection, the taxpayer may elect, or the department may require in order to fairly represent the business activity of the taxpayer in this state, the use of the method set forth in this paragraph.

(A) The amount of interest, dividends, net gains (but not less than zero) and other income from investment assets and activities in the investment account to be attributed to this state and included in the numerator is determined by multiplying all such income from such assets and activities by a fraction, the numerator of which is the gross receipts from such assets and activities which are properly assigned to a regular place of business of the taxpayer within this state and the denominator of which is the gross income from all such assets and activities.

(B) The amount of interest from federal funds sold and purchased and from securities purchased under resale agreements and securities sold under repurchase agreements attributable to this state and included in the numerator is determined by multiplying the amount described in (k)(i)(A) of this subsection from such funds and such securities by a fraction, the numerator of which is the gross income from such funds and such securities which are properly assigned to a regular place of business of the taxpayer within this state and the denominator of which is the gross income from all such funds and such securities.

(C) The amount of interest, dividends, gains and other receipts from trading assets and activities including, but not limited to, assets and activities in the matched book, in the arbitrage book and foreign currency transactions (but excluding amounts described in (k)(ii)(A) or (B) of this subsection), attributable to this state and included in the numerator is determined by multiplying the amount described in (k)(i)(B) of this subsection by a fraction, the numerator of which is the gross income from such trading assets and activities which are properly assigned to a regular place of business of the taxpayer within this state and the denominator of which is the gross income from all such assets and activities.

(iv) If the taxpayer elects or is required by the department to use the method set forth in (k)(iii) of this subsection, it must use this method on all subsequent returns unless the taxpayer receives prior permission from the department to use, or the department requires a different method.

(v) The taxpayer has the burden of proving that an investment asset or activity or trading asset or activity was properly assigned to a regular place of business outside of this state by demonstrating that the day-to-day decisions regarding the asset or activity occurred at a regular place of business outside this state. If the day-to-day decisions regarding an investment asset or activity or trading asset or activity occur at more than one regular place of business and one such regular place of business is in this state and one such regular place of business is outside this state, such asset or activity is considered to be located at the regular place of business of the taxpayer where the investment or trading policies or guidelines with respect to the asset or activity are established. Such policies and guidelines are presumed, subject to rebuttal by preponderance of the evidence, to be established at the commercial domicile of the taxpayer.

(l) Attribution of certain receipts to commercial domicile. All receipts which would be assigned under this rule to a state in which the taxpayer is not taxable are included in the numerator of the receipts factor, if the taxpayer's commercial domicile is in this state.

(5) **Effective date.** This rule applies to gross income that is reportable with respect to tax liability beginning on and after June 1, 2010.