TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #01-301

DIGEST

Amends 405 IAC 5-19-1 to clarify the definition of medical and surgical supplies. The amendments provide restrictions and limitations for coverage, and provide that reimbursement shall be equal to the lower of the provider's submitted charges or the Medicaid allowable amount for each item. The amendments require that all medical supplies be billed using health care financing administration common procedure coding system in accordance with the instructions set forth in the Indiana health coverage programs manual or update bulletins. Effective 30 days after filing with the secretary of state.

405 IAC 5-19-1

SECTION 1. 405 IAC 5-19-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-1 Medical supplies

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. (a) ~~Medicaid~~ **Medical and surgical supplies (medical supplies) are disposable items that are not reusable and must be replaced on a frequent basis. Medical supplies are used primarily and customarily to serve a medical purpose, are generally not useful to a person in the absence of an illness or injury, and are covered only for the treatment of a medical condition.** Reimbursement is available for medical supplies subject to the restrictions listed in this section.

(b) Medical supplies include, but are not limited to, the following items:

(1) Antiseptics and solutions.
(2) Bandages and dressing supplies.
(3) Gauze pads.
(4) Catheters.
(5) Incontinence supplies.
(6) Irrigation supplies.
(7) Diabetic supplies.
(8) Ostomy supplies.
(9) Respiratory and tracheotomy supplies.

(c) Covered medical supplies do not include the following items:

(1) Drug products, either legend or nonlegend.
(2) Sanitary napkins.
(3) Cosmetics.
(4) Dentifrice items.
(5) Tissue.
(6) Nonostomy deodorizing products, soap, disposable wipes, shampoo, or other items generally used for personal hygiene.

(d) Providers shall bill in accordance with the instructions set forth in the Indiana health coverage programs manual or update bulletins.

~~(b) Incontinency~~ **(e) Incontinence** supplies, including underpads, incontinent briefs and liners, diapers, and disposable diapers are covered subject to ~~prior authorization and~~ the following limitations:

(1) The supplies in this subsection are covered only in cases of documented necessity, at a rate determined by the ~~contractor.~~ **office.**

(2) The supplies in this subsection are covered only for recipients three (3) years of age or older.

~~(c)~~ **(f)** All medical supplies must be ordered in writing by a physician **or dentist.**

~~(d)~~ **(g)** Medical ~~and nonmedical~~ supplies ~~used in the usual care and treatment of a recipient in a long term care facility are included in the approved per diem rate for the facility and may not be billed separately by the facility or through a pharmacy or other provider.~~ **that are included in facility reimbursement, or that are otherwise included as part of reimbursement for a medical or surgical procedure, are not separately reimbursable to any party. All covered medical supplies, whether for routine or nonroutine use, are included in the per diem for nursing facilities, even if the facility does not include the cost of medical supplies in their facility cost reports.**

(h) Reimbursement is not available for medical supplies dispensed in quantities greater than a one (1) month supply for each calendar month, except when packaged by the manufacturer only in larger quantities.

(i) Medical supplies shall be for a specific medical purpose, not incidental or general-purpose usage.

(j) Reimbursement for medical supplies is equal to the lower of the following:

(1) The provider's submitted charges, not to exceed the provider's usual and customary charges.
(2) The Medicaid allowable fee schedule amount as determined under this section.

(k) The Medicaid allowable fee schedule amount is the base statewide fee schedule amount adjusted by a multiplier. The base statewide fee schedule amount is equal to the lower of the Medicaid fee schedule amount in effect during SFY 2001 or the amount determined as follows:

(1) The average acquisition cost of the item, if available. If this amount is not available, then subdivision (2).
(2) The Indiana Medicare fee schedule amount, if avail-

able. If this amount is not available, then subdivision (3).
(3) The weighted median of providers' usual and customary charges, if available. If this amount is not available, then subdivision (4).
(4) The Medicaid fee schedule amount in effect during state fiscal year 2001, if available. If this amount is not available, then subdivision (5).
(5) The average Indiana Medicaid payment amount per item during state fiscal year 2001.

The base statewide fee schedule amount shall be adjusted by a multiplier of no less than seven-tenths (.7) and no greater than one and two-tenths (1.2). The purpose of the multiplier is to ensure that the fee schedule amount is consistent with other public health programs and to ensure that medical supply items are available to Indiana Medicaid providers at or below the statewide fee schedule amount. The office may review annually the statewide fee schedule and adjust the fee schedule as necessary using the Medicare fee schedule, the provider's usual and customary charges, and the providers' acquisition cost information.

(l) Providers must bill for medical supplies using health care financing administration common procedure coding system in accordance with the instructions set forth in the Indiana health coverage programs manual or update bulletins.

(m) Providers must include their usual and customary charge for each medical supply item when submitting claims for reimbursement. Providers shall not use the Medicaid calculated allowable fee schedule amount for their billed charge unless it is less than or equal to the amount charged by the provider to the general public. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; filed Sep 27, 1999, 8:55 a.m.: 23 IR 313; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on September 3, 2002 at 10:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room A, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to the Indiana health coverage program's (Indiana Medicaid) definition, coverage, and reimbursement of medical and surgical supplies.

In accordance with the public notice requirements of 447.205 of Title 42, Code of Federal Regulations, the Indiana Family and Social Services Administration publishes this notice of proposed amendments to the Medicaid definition, coverage, and reimbursement of medical and surgical supplies.

The proposed amendments define medical and surgical supplies, provide restrictions and limitations for their coverage, and provide that reimbursement shall be equal to the lower of the provider's submitted charges or the Medicaid allowable amount for each item. Providers must bill for medical supplies using health care financing administration common procedure coding system in accordance with the instructions set forth in the Indiana health coverage programs manual or update bulletins.

The amendments are required to provide reimbursement for medical supply items that are consistent with other private and public payors, to clarify the definition of medical and surgical supplies, including a specific enumeration of items that are covered, and to provide for a review and adjustment of fee schedule amounts as necessary to reflect changes in market conditions and product availability. The proposed amendments are expected to result in reduced payments to Medicaid providers of $3.1 million annually.

The amendments will be effective upon approval from the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) of the state plan amendments and the completion of changes to the Indiana Administrative Code.

Copies of these rules are now on file at the Office of Medicaid Policy and Planning, Indiana Government Center-South, 402 West Washington Street, Room W382 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection. Also, copies of this notice and the proposed rule will be available for public review by contacting the director of the local office of the division of family and children, except in Marion County. The inspection material will be available for public viewing in Marion County at the Office of Medicaid Policy and Planning, 402 West Washington Street, Room W382, and will be available from 8:30 a.m. to 4:30 p.m., Monday through Friday. Written comments concerning these proposed amendments should be directed to: Marc Shirley, Pharmacy Program Director, Office of Medicaid Policy and Planning, MS07, 402 West Washington Street, Indianapolis, Indiana 46204. Written comments may be viewed by contacting Marc Shirley at (317) 232-4343.

John Hamilton
Secretary
Office of the Secretary of Family and Social Services

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #01-373

DIGEST

Amends 405 IAC 6-2-3, 405 IAC 6-2-5, 405 IAC 6-2-9, 405

IAC 6-2-12, 405 IAC 6-2-14, 405 IAC 6-2-18, 405 IAC 6-2-20, 405 IAC 6-2-21, 405 IAC 6-3-2, 405 IAC 6-3-3, 405 IAC 6-4-2, 405 IAC 6-5-1, 405 IAC 6-5-2, 405 IAC 6-5-3, 405 IAC 6-5-4, 405 IAC 6-5-5, 405 IAC 6-5-6, 405 IAC 6-6-2, 405 IAC 6-6-3, and 405 IAC 6-6-4 concerning provisions affecting applicants, enrollees, eligibility and enrollment requirements, benefits, and policy for the Indiana prescription drug program. Adds 405 IAC 6-2-5.3, 405 IAC 6-2-5.5, 405 IAC 6-2-12.5, 405 IAC 6-2-16.5, 405 IAC 6-2-20.5, 405 IAC 6-2-22.5, 405 IAC 6-8, and 405 IAC 6-9 concerning provisions that will set forth procedures for point of service processing and provider claims, payments, overpayments, and appeals for the Indiana prescription drug program. Effective 30 days after filing with the secretary of state.

405 IAC 6-2-3	**405 IAC 6-3-2**
405 IAC 6-2-5	**405 IAC 6-3-3**
405 IAC 6-2-5.3	**405 IAC 6-4-2**
405 IAC 6-2-5.5	**405 IAC 6-5-1**
405 IAC 6-2-9	**405 IAC 6-5-2**
405 IAC 6-2-12	**405 IAC 6-5-3**
405 IAC 6-2-12.5	**405 IAC 6-5-4**
405 IAC 6-2-14	**405 IAC 6-5-5**
405 IAC 6-2-16.5	**405 IAC 6-5-6**
405 IAC 6-2-18	**405 IAC 6-6-2**
405 IAC 6-2-20	**405 IAC 6-6-3**
405 IAC 6-2-20.5	**405 IAC 6-6-4**
405 IAC 6-2-21	**405 IAC 6-8**
405 IAC 6-2-22.5	**405 IAC 6-9**

SECTION 1. 405 IAC 6-2-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-2-3 "Benefit period" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. "Benefit period" means a specified time frame during which an enrollee accrues **or expends** the cost of prescription drugs. The benefit periods are specified in 405 IAC 6-5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

SECTION 2. 405 IAC 6-2-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-2-5 "Complete application" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. "Complete application" means an application which includes the following information about the applicant and applicant's spouse, if applicable:

(1) Name.
(2) Address **of domicile.**
(3) Date of birth.
(4) Social Security number.
(5) Marital status.
~~(4)~~ **(6)** Whether the ~~person~~ **applicant** had health insurance **with a prescription drug benefit** in the past ~~six (6) months.~~ **year.**
~~(5)~~ **(7)** Whether the ~~person~~ **applicant currently** has insurance that includes a prescription drug benefit.
~~(6)~~ **(8)** Whether the ~~person~~ **applicant** is on Medicaid, **including Medicaid with a spend-down.**
~~(7)~~ **(9)** Whether the ~~person~~ **applicant** has ~~lived~~ **resided** in Indiana for at least ninety (90) days in the past twelve (12) months.
~~(8)~~ **(10)** Proof of income.
~~(9)~~ **(11)** Signature.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-5; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)

SECTION 3. 405 IAC 6-2-5.3 IS ADDED TO READ AS FOLLOWS:

405 IAC 6-2-5.3 "Complete claim" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5.3. "Complete claim" means a claim submitted by a provider for processing that contains the enrollee's name and for each drug listed all of the following information:

(1) The day the drug was dispensed.
(2) The corresponding National Drug Code (NDC) number.
(3) The identification of prescribing physician.
(4) The name and dosage of drug.
(5) The provider's selling price in accordance with 405 IAC 6-8-3.
(6) If discounts are given, the actual price enrollee paid for the drug.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-5.3)

SECTION 4. 405 IAC 6-2-5.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 6-2-5.5 "Domicile" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5.5. "Domicile" means the applicant's true, fixed, principal, and permanent home. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-5.5)*

SECTION 5. 405 IAC 6-2-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-2-9 "Family" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 9. "Family" means the applicant, spouse, and any child

who ~~live~~ **reside** in the same residence. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-9; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

SECTION 6. 405 IAC 6-2-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-2-12 "Health insurance with a prescription drug benefit" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 12. "Health insurance with a prescription drug benefit" means any contract with an insurance company or organization approved or recognized by the Indiana Department of Insurance, under which an individual receives health benefits, including a prescription drug benefit. This term includes Medicaid and veteran's benefits. A prescription discount ~~card~~ offered by an insurance company, **department, manufacturer, provider,** or organization is not considered to be a prescription drug **insurance** benefit. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-12; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

SECTION 7. 405 IAC 6-2-12.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 6-2-12.5 "Income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 12.5. "Income" means the amount of money or its equivalent received in exchange for or as a result of labor or services, from the sale of goods or property or as profits from financial investments. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-12.5)*

SECTION 8. 405 IAC 6-2-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-2-14 "Net income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 14. "Net income" means the earned **income minus tax deductions, tax exemptions, and other tax reductions,** and unearned income **minus Medicare premiums** that an applicant and an applicant's family receives, calculated on a monthly basis. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-14; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

SECTION 9. 405 IAC 6-2-16.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 6-2-16.5 "Point of service" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 16.5. "Point of service" means receiving the program benefit at the time of purchase of the prescription drugs. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-16.5)*

SECTION 10. 405 IAC 6-2-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-2-18 "Prescription printout" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 18. "Prescription printout" means an itemized report prepared by a ~~pharmacy~~ **provider** for an enrollee showing prescription data for the enrollee for a stated benefit period. Such prescription data must include, but is not limited to, **the following:**

(1) Enrollee name and address.
(2) Prescription number.
(3) NDC code.
(4) Drug name.
(5) Drug strength.
(6) Dosage form.
(7) Quantity dispensed.
(8) Date of dispense. ~~and~~
(9) The amount of any discount provided.
~~(9)~~ **(10)** The amount paid by the enrollee or any insurance plan.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-18; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)

SECTION 11. 405 IAC 6-2-20 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-2-20 "Proof of income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 20. "Proof of income" means documentation of the ~~earned and unearned~~ income of an applicant and an applicant's family. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-20; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

SECTION 12. 405 IAC 6-2-20.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 6-2-20.5 "Provider" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16; IC 25-26-13-17

Sec. 20.5. (a) "Provider" means an entity who:
(1) participates in the program;
(2) is licensed under IC 25-26-13;
(3) holds a proper permit under IC 25-26-13-17; and
(4) complies with the same state enrollment requirements established for the Medicaid program at 405 IAC 5-4.

(b) Nothing in this rule prevents an enrolled provider from dispensing a prescription from an out-of-state branch location as long as the:

(1) provider has an Indiana presence and is enrolled under the provisions of this article; and

(2) branch location where the prescription is dispensed is located within the United States of America.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-20.5)

SECTION 13. 405 IAC 6-2-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-2-21 "Refund certificate" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 21. "Refund certificate" means the **claim** document issued to an enrollee by the office ~~which~~ **that** authorizes the enrollee, **who has not received a benefit at point of service,** to request a refund for prescription drugs purchased during a benefit period. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-21; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

SECTION 14. 405 IAC 6-2-22.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 6-2-22.5 "Reside" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 22.5. "Reside" means the place where an applicant actually lives as distinguished from a domicile. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-22.5)*

SECTION 15. 405 IAC 6-3-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-3-2 Date of application

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. For purposes of determining the effective date of availability of the program to an applicant, the date of application is the date the **complete** application is received by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 6-3-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

SECTION 16. 405 IAC 6-3-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-3-3 Date of availability

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. **(a)** The program is available to an ~~applicant~~ **enrollee** beginning with the benefit period prior to the one in which the ~~applicant applies~~ **enrollee applied** for enrollment in the program.

(b) After July 1, 2002, program availability will be no sooner than the date complete application is received and approved.

(c) Those enrollees applying on or before the tenth of a month will have point of service benefits available on the first day of the following month. Those enrollees applying after the tenth of a month will have point of service benefits available no later than the first day of the second following month.

(d) The program is not available for prescription drugs purchased prior to the month in which the ~~applicant~~ **enrollee** turned sixty-five (65) years of age. *(Office of the Secretary of Family and Social Services; 405 IAC 6-3-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

SECTION 17. 405 IAC 6-4-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-4-2 Income

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) To be eligible for the program, an applicant's monthly family net income must not exceed the income limit listed below for the applicant's family size:

Family Size	Net Monthly Income Limit
1	~~$940~~ **$997**
2	~~$1,266~~ **$1,344**
3	~~$1,592~~ **$1,690**

(b) For each additional family member over three (3), the family member standard shall be added to the net monthly income limit for a family of three in order to calculate the net monthly income limit. A child who earns more than the family member standard per month is not included in the calculation of monthly net income or in family size.

(c) The monthly net income limits are determined by multiplying the **annual** federal poverty guideline **amounts** for each family size by one hundred thirty-five percent (135%), dividing by twelve (12), and then rounding up to the next whole dollar.

(d) The income standards in subsection (a) shall increase annually in the same percentage (%) amount that is applied to the federal poverty guideline. The increase shall be effective on the first day of the second month following the month of publication of the federal poverty guideline in the Federal Register. *(Office of the Secretary of Family and Social Services; 405 IAC 6-4-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

SECTION 18. 405 IAC 6-5-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-5-1 Prescription drug coverage
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. **(a)** The program shall issue a partial refund to an enrollee for the purchase of prescription drugs, as defined under this article, based upon the limitations set forth in this rule **if an enrollee submits a refund certificate.**

(b) Rather than submit a refund certificate, an eligible enrollee may go to any participating provider to purchase prescription drugs and present his or her prescription and program identification card at the point of service to receive immediate program benefits. At the point of service, the provider shall determine the following:

(1) Whether the enrollee is eligible.

(2) Whether the individual whose name appears on the identification card is the same as the individual for whom the prescription is written.

(3) Whether the enrollee has benefits available.

(4) The price of a prescription drug in accordance with 405 IAC 6-8-3.

(5) That all prescription discounts, if applicable, are taken after the appropriate drug price has been determined.

(6) The amount of the enrollee's copayment.

(Office of the Secretary of Family and Social Services; 405 IAC 6-5-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)

SECTION 19. 405 IAC 6-5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-5-2 Benefit defined by family income level
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) The refund **or benefit at the time of purchase, which is** issued to an enrollee per benefit period, is limited by family **monthly net** income as follows:

Income Guideline	Individual's Monthly Net Income	Couple's Monthly Net Income	Annual Benefit
Up to 135% of federal poverty guideline	Up to ~~$940~~ **$997** per month	Up to ~~$1,266~~ **$1,344** per month	50% ~~refund,~~ **benefit,** up to $500 benefit/year
Up to 120% of federal poverty guideline	Up to ~~$835~~ **$886** per month	Up to ~~$1,125~~ **$1,194** per month	50% ~~refund,~~ **benefit,** up to $750 benefit/year
Under 100% of federal poverty guideline	Up to ~~$696~~ **$739** per month	Up to ~~$938~~ **$995** per month	50% ~~refund,~~ **benefit,** up to $1,000 benefit/year

(b) An enrollee and spouse who are enrolled in the program will each receive the maximum refund, ~~of~~ **or benefit at the time of purchase, for** prescription drug expenses up to the annual benefit in subsection (a) for which they qualify by family income level.

(c) ~~The benefit income guidelines are determined by multiplying the federal poverty guideline for each family size by each income guideline percentage (%), dividing by twelve (12), and then rounding up to the next whole dollar.~~ **Upon such time as the enrollee exceeds the annual benefit, the enrollee may use the program identification card to access program benefit prescription drug rates as defined by 405 IAC 6-8-3 and 405 IAC 6-8-4 until the enrollee benefit period expires.**

~~(d) The benefit income guidelines in subsection (a) shall increase annually in the same percentage (%) amount that is applied to the federal poverty guideline. The increase shall be effective on the first day of the second month following the month of publication of the federal poverty guideline in the Federal Register.~~ *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

SECTION 20. 405 IAC 6-5-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-5-3 Benefit period
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. **(a)** The **refund certificate** program shall consist of four **(4)** benefit periods per year, defined as follows:

(1) Benefit period one: October 1 through December 31.

(2) Benefit period two: January 1 through March 31.

(3) Benefit period three: April 1 through June 30.

(4) Benefit period four: July 1 through September 30.

(b) The point of service benefit shall be one (1) year of continuous eligibility up to the benefit limit in accordance with section 2 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

SECTION 21. 405 IAC 6-5-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-5-4 Benefit duration
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. **(a)** The **refund certificate** program is available to an enrollee for a maximum of four (4) consecutive benefit periods.

(b) The point of service benefit is available to an enrollee for one (1) year.

(c) If an enrollee is utilizing both the refund certificate program and the point of service program, the maximum benefit duration to an enrollee is one (1) year of continuous benefits.

(d) To reenroll in the **refund certificate** program ~~following the expiration of the enrollee's last benefit period,~~ **or for point of service benefits** a new application must be submitted to the office in accordance with this article. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

SECTION 22. 405 IAC 6-5-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-5-5 Benefit period ineligibility
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. ~~(a)~~ An enrollee is ineligible for a ~~refund~~ **program benefit** for prescription drugs purchased during any benefit period in which the enrollee has health insurance **or Medicaid** with a prescription drug benefit.

~~(b) Ineligibility for a refund under (a) does not terminate enrollment in the program. An enrollee may request a refund during any later benefit period during which the enrollee does not have health insurance with a prescription drug benefit.~~ *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-5; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

SECTION 23. 405 IAC 6-5-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-5-6 Benefits; program appropriations
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 6. (a) Upon submission of a completed refund certificate, **or at the point of service,** benefits are available under this program on a first come, first ~~serve~~ **served** basis.

(b) Benefits will exist under this program to the extent that appropriations are available for the program.

(c) The state budget director shall determine if appropriations are available to continue **offering and** paying benefits to enrollees. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-6; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460)*

SECTION 24. 405 IAC 6-6-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-6-2 Letter of eligibility
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. Once the office has ~~processed a complete application,~~ **determined eligibility,** the applicant will receive a letter of eligibility ~~by mail~~ notifying the applicant of his or her status in the program. An applicant will either be eligible and enrolled in the program, or ineligible and not enrolled in the program. **New applicants determined to be eligible after July 1, 2002, will receive an approved letter of eligibility and a program benefit card.** *(Office of the Secretary of Family and Social Services; 405 IAC 6-6-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)*

SECTION 25. 405 IAC 6-6-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-6-3 Refund certificates
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) An enrollee will receive up to four (4) refund certificates with a letter of eligibility which enrolls the applicant into the program.

(b) Each refund certificate corresponds to one (1) of four (4) refund periods as defined ~~below:~~ **as follows:**
(1) Refund period one: January 1 through March 31.
(2) Refund period two: April 1 through June 30.
(3) Refund period three: July 1 through September 30.
(4) Refund period four: October 1 through December 31.

(c) Each refund period corresponds to one (1) benefit period as set forth ~~below:~~ **as follows:**

Benefit Period	Refund Period
October 1 through December 31	January 1 through March 31
January 1 through March 31	April 1 through June 30
April 1 through June 30	July 1 through September 30
July 1 through September 30	October 1 through December 31

(d) Refund certificates will not be available on or after July 1, 2002.

(e) Refund certificates for July–September 2002 will be the last quarter paid by the program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-6-3; filed Mar 8, 2001, 11:19 a.m. 24 IR 2461)*

SECTION 26. 405 IAC 6-6-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 6-6-4 Refund certificate redemption
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) **If the enrollee is using a refund certificate,** during each refund period, the enrollee must submit the applicable refund certificate with the prescription printout for the corresponding benefit period to the office in the manner prescribed by the office.

(b) The refund period deadline is the date which corresponds to the later of thirty-five (35) days from the date on the letter of eligibility or the last day of the applicable refund period.

(c) An enrollee will be notified by mail if the enrollee submits an incomplete request for refund. An incomplete request for refund includes:

(1) an unsigned refund certificate;

(2) a refund certificate with no insurance verification;

(3) a prescription printout which fails to state all information in ~~405 IAC 6-2-17;~~ **405 IAC 6-2-18;**

(4) the absence of a refund certificate for the applicable benefit period;

(5) the absence of a prescription printout for the applicable benefit period; or

(6) the absence of any other information that is necessary under this article to process a refund request.

The enrollee must submit the information requested in the letter of notification by the deadline in the letter of notification.

(d) **A** refund ~~certificates~~ **certificate** received by the office after the refund deadline date will not be processed and no refund will be issued. Any refund certificate or prescription printout requested in **subsection** (c) that is received by the office after the stated deadline date will not be processed and no refund will be issued. *(Office of the Secretary of Family and Social Services; 405 IAC 6-6-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)*

SECTION 27. 405 IAC 6-8 IS ADDED TO READ AS FOLLOWS:

Rule 8. Provider Appeal; Records; Drug Price; Dispensing Fee

405 IAC 6-8-1 Provider appeal procedures
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. All provider appeals from office action taken under this article shall be governed by the procedures and time limits for Medicaid providers set out in 405 IAC 1-1.5 and 405 IAC 6-9-1, if applicable. *(Office of the Secretary of Family and Social Services; 405 IAC 6-8-1)*

405 IAC 6-8-2 Provider records
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. The provisions of 405 IAC 1-5 concerning contents, retention, and disclosure of records of Medicaid providers shall apply to providers of covered drugs under this title. *(Office of the Secretary of Family and Social Services; 405 IAC 6-8-2)*

405 IAC 6-8-3 Drug price methodology
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. Drug prices for purposes of determining provider reimbursement and enrollee copayment shall be calculated using the reimbursement methodology for Medicaid prescription drugs under rules adopted by the secretary at 405 IAC 5-24. *(Office of the Secretary of Family and Social Services; 405 IAC 6-8-3)*

405 IAC 6-8-4 Dispensing fee
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. The Indiana prescription drug dispensing fee maximum under this title shall be the same as that which is allowable under rules adopted by the secretary at 405 IAC 5-24-6. *(Office of the Secretary of Family and Social Services; 405 IAC 6-8-4)*

SECTION 28. 405 IAC 6-9 IS ADDED TO READ AS FOLLOWS:

Rule 9. Provider Claims; Payments; Overpayments; Sanctions

405 IAC 6-9-1 Filing of claims; filing date; payment liability
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) All provider claims for payment for point of service benefits rendered to enrollees must be originally filed with the office's contractor within twelve (12) months of the date of the provision of the service. A provider who is dissatisfied with the amount of his or her reimbursement may appeal under the provisions of 405 IAC 6-8-1. However, prior to filing such an appeal, the provider must:

(1) resubmit the claim if the reason for denial of payment was due to incorrect or inaccurate billing by the provider;

(2) submit, if appropriate, an adjustment request to the office contractor's adjustment and resolution unit; or

(3) submit a written request to the office's contractor, stating why the provider disagrees with the denial or amount of reimbursement.

(b) All requests for payment adjustments and/or reconsideration of a claim that has been denied must be submitted to the office contractor within sixty (60) days of the date of notification that the claim was paid or denied. In order to be considered for payment, each subsequent claim resubmission or adjustment request must be submitted within sixty (60) days of the most recent notification that the claim was paid or denied. The date of notification shall be considered to be three (3) days following the date of mailing from the office's contractor. All claims filed after twelve (12) months of the date of the provision of the service, as well as claims filed after sixty (60) days of the date of notification that the claim was paid or denied shall be rejected for payment unless a waiver has been granted.

In extenuating circumstances a waiver of the filing limit may be authorized by the contractor or the office when justification is provided to substantiate why the claim could not be filed or refiled within the filing limit. Some examples of situations considered to be extenuating circumstances are as follows:

(1) Contractor or state error or action that has delayed payment.

(2) Reasonable and continuous attempts on the part of the provider to resolve a claim problem.

(c) All claims filed for reimbursement shall be reviewed prior to payment by the office or its contractor, for completeness, including required documentation, appropriateness of services and charges, application of discounts, and other areas of accuracy and appropriateness as indicated.

(d) The office is only liable for the payment of claims filed by providers who were certified providers at the time the service was rendered and for services provided to persons who were enrolled in the Indiana prescription drug program as eligible enrollees at the time service was provided. The claim will not be paid if the services provided are outside the service parameters as established by the office.

(e) A provider shall collect from an enrollee or from the authorized representative of the enrollee that portion of his or her charge for a benefit as defined by 405 IAC 6-5-2, which is not reimbursed by the Indiana prescription drug program and after all prescription discounts have been calculated in accordance with this article. *(Office of the Secretary of Family and Social Services; 405 IAC 6-9-1)*

405 IAC 6-9-2 Denial of claim payment; basis

Authority: IC 12-10-16-5
Affected: IC 4-21.5-3-7; IC 4-21.5-4; IC 12-10-16

Sec. 2. (a) The office may deny payment, or instruct the contractor to deny payment, to any provider if, after investigation by the office, the office's designee, or other governmental authority, the office finds any of the following:

(1) The services claimed cannot be documented by the provider in accordance with 405 IAC 6-8-2.

(2) The services claimed were provided to a person other than a person in whose name the claim is made.

(3) The services claimed were provided to a person who was not eligible for benefits at the time of the provision of the service.

(4) The claim arises out of any of the following acts or practices:

(A) Presenting, or causing to be presented, for payment any false or fraudulent claim.

(B) Submitting, or causing to be submitted, information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(C) Submitting, or causing to be submitted, any false information.

(D) Failure to disclose, or make available to the office, or its authorized agent, records of services provided to enrollees and records of payments made therefor.

(E) Engaging in a course of conduct or performing an act deemed by the office to be improper or abusive of the program or continuing such conduct following notification that the conduct should cease.

(F) Breach of the terms of the Indiana prescription drug pharmacy provider agreement and/or failure to comply with the terms of the provider certification on the claim form.

(G) Violating any provision of state law or any rule or regulation promulgated pursuant to this article or any provider bulletin published thereto.

(H) Submission of a false or fraudulent application for provider status.

(I) Failure to meet standards required by the state for participating in the program.

(J) Refusal to execute a new Indiana prescription drug pharmacy provider agreement when requested by the office or its contractor to do so.

(K) Failure to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office.

(L) Failure to repay within sixty (60) days or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments, except as provided in this rule.

(M) Presenting claims for which benefits are not available.

(5) The claim arises out of any act or practice prohibited by rules and regulations of the office.

(b) The decision as to denial of payment for a particular claim or claims is at the discretion of the office. This decision shall be final and:

(1) will be mailed to the provider by United States mail at the address contained in the office records and on the claims or transmitted electronically if the provider has elected to receive electronic remittance advices;

(2) will be effective upon receipt; and

(3) may be administratively appealed in accordance with this article.

(c) The decision as to claim payment suspension is at the discretion of the office, and may include either of the following:

(1) The denial of payment for all claims that have been submitted by the provider pending further investigation by the office, the office's designee, or other governmental authority.

(2) The suspension or withholding of payment on any or all claims of the provider pending an audit or further investigation by the office, the office's designee, or other governmental authority.

(d) The decision of the office under subsection (c) shall:
(1) be served upon the provider by certified mail, return receipt requested;
(2) contain a brief description of the decision;
(3) become final fifteen (15) days after its receipt; and
(4) contain a statement that any appeal from the decision shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.

(e) If an emergency exists, as determined by the office, the office may issue an emergency directive suspending or withholding payment on any or all claims of the provider pending further investigation by the office, the office's designee, or other governmental authority under IC 4-21.5-4. Any order issued under this subsection shall:
(1) be served upon the provider by certified mail, return receipt requested;
(2) become effective upon receipt;
(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and
(4) contain a statement that any appeal from the decision of the assistant secretary made under this subsection shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.

(Office of the Secretary of Family and Social Services; 405 IAC 6-9-2)

405 IAC 6-9-3 Overpayments made to providers; recovery
Authority: IC 12-10-16-5
Affected: IC 4-21.5-3; IC 6-8.1-10-1; IC 12-10-16

Sec. 3. (a) The office may recover payment, or instruct its contractor to recover payment, from any provider for services rendered to an individual, or claimed to be rendered to an individual, if the office, after investigation or audit, finds that:
(1) the services paid for cannot be documented by the provider as required by 405 IAC 6-8-2;
(2) the services were provided to a person other than the person in whose name the claim was made and paid;
(3) the service reimbursed was provided to a person who was not eligible for benefits at the time of the provision of the service;
(4) the paid claim arises out of any act or practice prohibited by law or by rules of the office;
(5) overpayment resulted from an inaccurate description of prescription data;
(6) overpayment resulted from duplicate billing; and
(7) overpayment to the provider resulted from any other reason not specified in this subsection.

(b) The office may determine the amount of overpayments made to a provider by means of a random sample audit. The random sample audit shall be conducted in accordance with generally accepted statistical methods, and the selection criteria shall be based on a table of random numbers derived from any book of random sampling generally accepted by the statistical profession.

(c) The office or its designee may conduct random sample audits for the purpose of determining overcharges to the Indiana prescription drug program. The following criteria apply to random sample audits:
(1) In the event that the provider wishes to appeal the accuracy of the random sample methodology under IC 4-21.5-3, the provider may present evidence to show that the sample used by the office was invalid and therefore cannot be used to project the overpayments identified in the sample to total billings for the audit period.
(2) The provider may also conduct an audit, at the provider's expense, of either a valid random sample audit, using the same random sampling methodology as used by the office, or an audit of one hundred percent (100%) of medical records of payments received during the audit period. Any such audit must be completed within one hundred eighty (180) days of the date of appeal and must demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with state and federal law. The provider must submit supporting documentation to demonstrate this compliance.

(d) If the office determines that an overcharge has occurred, the office shall notify the provider by certified mail. The notice shall include a demand that the provider reimburse the office, within sixty (60) days of the provider's receipt of the notification, for any overcharges determined by the office. Except as provided in subsection (f), a provider who receives a notice and request for repayment may elect to do one (1) of the following:
(1) Repay the amount of the overpayment not later than sixty (60) days after receiving notice from the office, including interest from the date of overpayment.
(2) Request a hearing and repay the amount of the alleged overpayment not later than sixty (60) days after receiving notice from the office.
(3) Request a hearing not later than sixty (60) days after receiving notice from the office and not repay the alleged overpayment, except as provided in subsection (e).

(e) If:
(1) a provider elects to proceed under subsection (d)(3); and
(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider owes the money;
the provider shall pay the amount of the overpayment, including interest from the date of the overpayment.

(f) The office may enter into an agreement with the provider regarding the repayment of any overpayment made to the provider. Such agreement shall state that the amount of overpayment shall be deducted from subsequent

payments to the provider. Such subsequent payment deduction shall not exceed a period of six (6) months from the date of the agreement. The repayment agreement shall include provisions for the collection of interest on the amount of the overpayment. Such interest shall not exceed the percentage rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c).

(g) Whenever the office determines, after an investigation or audit, that an overpayment to a provider should be recovered, the office shall assess an interest charge in addition to the amount of overpayment demanded. Such interest charge shall not exceed the rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c). Such interest charge shall be applied to the total amount of the overpayment, less any subsequent repayments. The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists. When an overpayment is determined pursuant to the results of a random sample audit, the date the overpayment occurred shall be considered to be the last day of the audit period, and interest will be calculated from the last day of the audit period. Recovering interest:

(1) at a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report; and

(2) accruing from the date of overpayment on amounts paid to a provider that are in excess of the amount subsequently determined to be due the provider as a result of an audit, a reimbursement cost settlement or a judicial or an administrative proceeding.

(h) If the office recovers an overpayment to a provider that is subsequently found not to have been owing to the office, either in whole or in part, then the office will pay to the provider interest on the amount erroneously recovered from the provider. Such interest will accrue from the date that the overpayment was recovered by the office until the date the overpayment is restored to the provider. Such interest will accrue at the rate of interest set by the commissioner for interest payments from the department of state revenue to a taxpayer. The office will not pay interest to a provider under any other circumstances.

(i) If, after receiving a notice and request for repayment, the provider fails to elect one (1) of the options listed in subsection (d) within sixty (60) days and the administrator determines that reasonable grounds exist to suspect that the provider has acted in a fraudulent manner, then the office shall immediately certify the facts of the case to the appropriate county prosecutor. *(Office of the Secretary of Family and Social Services; 405 IAC 6-9-3)*

405 IAC 6-9-4 Repayment of overpayment to office

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) The office may require the repayment of any amount determined by the office to have been paid to the provider in error, prior to an evidentiary hearing or summary review, unless an appeal is pending and the provider has elected not to repay an alleged overpayment pursuant to section 3(d)(3) of this rule. The office may, in its discretion, recoup any overpayment to the provider by the following means:

(1) Offset the amount of the overpayment against current payments to a provider.

(2) Require that the provider satisfy the overpayment by refunding the entire amount of the overpayment to the office directly.

(3) Enter into an agreement with the provider in accordance with section 3 of this rule.

(b) Interest from the date of the overpayment will be assessed even if the provider repays the overpayment to the office within thirty (30) days after receipt of the notice of the overpayment. This subsection applies to any of the methods of recoupment set out in this section. *(Office of Family and Social Services; 405 IAC 6-9-4)*

405 IAC 6-9-5 Sanctions against providers; determination after investigation

Authority: IC 12-10-16-5
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7; IC 4-21.5-4; IC 12-10-16

Sec. 5. (a) If, after investigation by the office, the office's designee, or other governmental authority, the office determines that a provider has violated any provision of IC 12-10-16, or has violated any rule established under one (1) of those sections, the office may impose one (1) or more of the following sanctions:

(1) Deny payment to the provider for services rendered during a specified period of time.

(2) Reject a prospective provider's application for participation in the program.

(3) Remove a provider's certification for participation in the program (decertify the provider).

(4) Assess a fine against the provider in an amount not to exceed three (3) times the amounts paid to the provider in excess of the amounts that were legally due.

(5) Assess an interest charge, at a rate not to exceed the rate established within this article on the amounts paid to the provider in excess of the amounts that were legally due. The interest charge shall accrue from the date of the overpayment to the provider.

(b) Specifically, the office may impose the sanctions in subsection (a) if, after investigation by the office, the office's designee, or other governmental authority, the office determines that the provider did any of the following:

(1) Submitted, or caused to be submitted, claims for services which cannot be documented by the provider.
(2) Submitted, or caused to be submitted, claims for services provided to a person other than a person in whose name the claim is made.
(3) Submitted, or caused to be submitted, any false or fraudulent claims for services.
(4) Submitted, or caused to be submitted, information with the intent of obtaining greater compensation than that which the provider is legally entitled.
(5) Engaged in a course of conduct or performed an act deemed by the office to be abusive of the program or continuing such conduct following notification that the conduct should cease.
(6) Breached, or caused to be breached, the terms of the provider certification agreement.
(7) Failed to comply with the terms of the provider certification on the claim form.
(8) Overutilized, or caused to be overutilized, the program.
(9) Submitted, or caused to be submitted, a false or fraudulent provider certification agreement.
(10) Submitted, or caused to be submitted, any claims for services arising out of any act or practice prohibited by the criminal provisions of the Indiana Code or by the rules of the office.
(11) Failed to disclose or make available to the office, the office's designee, or other governmental authority, after reasonable request and notice to do so, documentation of services provided to enrollees and office records of payments made therefor.
(12) Failed to meet standards required by state law for participation.
(13) Charged an enrollee copayment for covered services over and above that allowable under this article.
(14) Refused to execute a new provider certification agreement when requested to do so.
(15) Failed to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office.
(16) Failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments, unless an appeal is pending and the provider has elected not to repay an alleged overpayment.

(c) The office may enter a directive imposing a sanction under IC 4-21.5-3-6. Any directive issued under this subsection shall:
(1) be served upon the provider by certified mail, return receipt requested;
(2) contain a brief description of the order;
(3) become final fifteen (15) days after its receipt; and
(4) contain a statement that any appeal from the decision of the office made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.

(d) If an emergency exists, as determined by the office, the office may issue an emergency directive imposing a sanction under IC 4-21.5-4. Any order issued under this subsection shall:
(1) be served upon the provider by certified mail, return receipt requested;
(2) become effective upon receipt;
(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and
(4) contain a statement that any appeal from the decision made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.

(e) The decision to impose a sanction shall be made at the discretion of the office. *(Office of the Secretary of Family and Social Services; 405 IAC 6-9-5)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on August 28, 2002 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room A, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to provide for point of sale benefits to Hoosier Rx (Indiana prescription drug program) enrollees. Written comments may be directed to the Indiana Government Center-South, 402 West Washington Street, Room W451, MS-27, Office of General Counsel, Attention: Maureen Bartolo, Indianapolis, Indiana 46204. Correspondence should be identified in the following manner: "COMMENTS RE: PROPOSED RULE LSA Document #01-373: Hoosier Rx POS". Written comments received will be made available for public display at the above listed address of the Office of General Counsel.

Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

John Hamilton
Secretary
Office of the Secretary of Family and Social Services

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #02-140

DIGEST

Amends 405 IAC 5-14-2, 405 IAC 5-14-3, 405 IAC 5-14-4, and 405 IAC 5-14-6 to limit the comprehensive or extensive

visits for recipients to two per year, and updates the rule to reflect current operating procedures. Add 405 IAC 5-14-2.5 to add copayments for dental services. Effective 30 days after filing with the secretary of state.

405 IAC 5-14-2 **405 IAC 5-14-4**
405 IAC 5-14-2.5 **405 IAC 5-14-6**
405 IAC 5-14-3

SECTION 1. 405 IAC 5-14-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-2 Covered services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. The following are covered dental services under the Indiana Medicaid program:
(1) Evaluations.
(2) Radiographs.
(3) Prophylaxis.
(4) Topical fluoride.
(5) Sealant.
(6) Amalgam.
(7) Unilateral and bilateral space maintainers.
(8) Resin anteriors and posteriors.
(9) Recement crowns.
(10) Steel crown primary.
(11) Stainless steel crown permanent.
(12) Pin retention.
(13) Pulpcap.
(14) Therapeutic pulpotomy.
(15) Extractions.
(16) Oral biopsies.
(17) Alveoplasty.
(18) Excision of lesions.
(19) Excision of benign tumor greater than one and twenty-five hundredths (1.25) centimeters.
(20) Odontogenic cyst removal.
(21) Nonodontogenic cyst removal.
(22) Incise and drain abscess.
(23) Sequestrectomy osteomyelitis.
(24) Fracture simple stabilize.
(25) Compound fracture of the mandible.
(26) Compound fracture of the maxilla.
(27) Repair of wounds.
(28) Suturing.
(29) Osteoplasty-for orthognathic deformity.
(30) Emergency treatment dental pain.
(31) Analgesia.
(32) Therapeutic drug injection.
(33) Drugs and medicaments.
(34) Treatment of complications postsurgery.
(35) Periodontal surgery limited to drug-induced periodontal hyperplasia.
(36) Other dental services as medically necessary to treat recipients eligible for the EPSDT program.
(37) Confirmatory consultations.
(38) Periodontal root planing and scaling.
(39) General anesthesia.
(40) Intravenous (IV) sedation.
(41) Dentures and partials.
(42) Orthodontic services for recipients twenty (20) years of age and under only.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 2. 405 IAC 5-14-2.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-14-2.5 Copayments for dental services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 2.5. In accordance with IC 12-15-6, a copayment will be required for dental services as follows:
(1) The copayment shall be made by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the recipient is liable.
(2) In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under this federal requirement, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.
(3) The provider shall collect from the recipient a copayment amount of up to three dollars ($3) per visit, based on the following schedule:
(A) Paid service up to ten dollars ($10), copayment equals fifty cents ($.50).
(B) Paid service from ten dollars and one cent ($10.01) to twenty-five dollars ($25), copayment equals one dollar ($1).
(C) Paid service from twenty-five dollars and one cent ($25.01) to fifty dollars ($50), copayment equals two dollars ($2).
(D) Paid service from fifty dollars ($50) and over, copayment equals three dollars ($3).
(4) The following dental services are exempt from the copayment requirement:
(A) Emergency dental services.
(B) Services furnished to individuals less than eighteen (18) years of age.
(C) Services furnished to pregnant women, if such services are related to a condition that may complicate the pregnancy.

(D) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-2.5)

SECTION 3. 405 IAC 5-14-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-3 Diagnostic services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. Medicaid reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs, and emergency treatments with the following limitations:

(1) Either full mouth series radiographs or panorex is limited to one (1) set per recipient every three (3) years.

(2) Bitewing, intra-oral, and extra-oral radiographs are limited to one (1) set per recipient every twelve (12) months. One (1) set is defined as a total of four (4) single films.

(3) A comprehensive or detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider, **with an annual limit of two (2) per recipient.**

(4) A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient, any provider.

(5) Mouth gum cultures and sensitivity tests are not covered.

(6) Oral hygiene instructions are reimbursed in the Medicaid payment allowance for diagnostic services and may not be billed separately to Medicaid.

(7) Payment for the writing of prescriptions is included in the reimbursement for diagnostic services and may not be billed separately to Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 4. 405 IAC 5-14-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-4 Topical fluoride

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. Reimbursement is available for one (1) topical application of fluoride every six (6) months per recipient only for patients who are ~~eighteen (18)~~ **twelve (12)** months of age or older but who are younger than ~~nineteen (19)~~ **twenty-one (21)** years of age. Topical applications of fluoride are not covered for recipients ~~nineteen (19)~~ **twenty-one (21)** years of age or older. Brush-in fluoride (topical application of fluoride phosphate) is not a covered service. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 5. 405 IAC 5-14-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-6 Prophylaxis

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. Prophylaxis is a covered service in accordance with the following limitations:

(1) One (1) unit every six (6) months for noninstitutionalized recipients ~~over eighteen (18)~~ **twelve (12)** months of age up to their twenty-first birthday.

(2) One (1) unit every twelve (12) months for noninstitutionalized recipients twenty-one (21) years of age and older.

(3) Institutionalized recipients may receive up to two (2) units every six (6) months.

(4) Prophylaxis is not covered for recipients under ~~eighteen (18)~~ **twelve (12)** months of age.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on August 27, 2002 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Government Center Auditorium, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to require copayments and limit comprehensive or extensive visits for Medicaid recipients. Written comments may be directed to the Indiana Government Center-South, 402 West Washington Street, Room W451, MS-27, Office of General Counsel, Attention: Maureen Bartolo, Indianapolis, Indiana, 46204. Correspondence should be identified in the following manner: "COMMENTS RE: PROPOSED RULE LSA Document #02-140: DENTAL COPAY". Written comments received will be made available for public display at the above listed address of the Office of General Counsel.

Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

John Hamilton
Secretary
Office of the Secretary of Family and Social Services

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #02-141

DIGEST

Amends 405 IAC 5-24-7 to revise copayment structure for drugs reimbursed by Medicaid. Brand name legend drugs will be subject to a three dollar ($3) copayment. Generic legend drugs, all nonlegend drugs, and compounded prescriptions will be subject to a fifty cent ($.50) copayment. Effective 30 days after filing with the secretary of state.

405 IAC 5-24-7

SECTION 1. 405 IAC 5-24-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-7 Copayment for legend and nonlegend drugs

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 7. (a) Under IC 12-15-6, a copayment is required for legend and nonlegend drugs and insulin in accordance with the following:

(1) The copayment shall be paid by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the recipient is liable.

(2) In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under 42 CFR 447.15, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

(3) The amount of the copayment will be as follows:

(A) Fifty cents ($0.50) for each generic **legend** drug dispensed. ~~irrespective of the Medicaid payment for the generic drug.~~

(B) Fifty cents ($0.50) for each ~~brand name~~ **nonlegend** drug dispensed, ~~for which the Medicaid payment is ten dollars ($10) or less.~~ **whether brand name or generic.**

~~(C) One dollar ($1) for each brand name drug dispensed for which the Medicaid payment is from ten dollars and one cent ($10.01) to thirty dollars ($30).~~

~~(D) Two dollars ($2) for each brand name drug dispensed for which the Medicaid payment is from thirty dollars and one cent ($30.01) to fifty-five dollars ($55).~~

~~(E)~~ **(C)** Three dollars ($3) for each brand name **legend** drug dispensed. ~~for which the Medicaid payment is fifty-five dollars and one cent ($55.01) or more.~~

(D) Fifty cents ($0.50) for each compounded prescription, whether legend or nonlegend.

The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid.

(b) The following pharmacy services are exempt from the copayment requirement:

(1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.

(2) Services furnished to individuals less than eighteen (18) years of age.

(3) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy.

(4) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions.

(5) Family planning services and supplies furnished to individuals of child bearing age.

(6) Health maintenance organization (HMO) pharmacy services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on August 29, 2002 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Rooms 4 and 5, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to revise the copayment structure for drugs reimbursed by Medicaid. Written comments may be directed to the Indiana Government Center-South, 402 West Washington Street, Room W451, MS-27 Office of General Counsel, Attention: Maureen Bartolo, Indianapolis, Indiana, 46204. Correspondence should be identified in the following manner: "COMMENTS RE: PROPOSED RULE AMENDMENT FOR MEDICAID DRUG COPAYMENTS LSA 02-141". Written comments received will be made available for public display at the above listed address of the Office of General Counsel. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

John Hamilton
Secretary
Office of the Secretary of Family and Social Services

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #02-144

DIGEST

Amends 405 IAC 1-14.5-13, 405 IAC 1-14.5-14, and 405

IAC 1-14.5-15 to change the index used in the calculation of the fair rental allowance from the United States Treasury 30 year bond to the United States Treasury 10 year bond. Effective 30 days after filing with the secretary of state.

405 IAC 1-14.5-13
405 IAC 1-14.5-14
405 IAC 1-14.5-15

SECTION 1. 405 IAC 1-14.5-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.5-13 Allowable costs; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 13. (a) The use fee limitation is based on the following:
(1) The assumption that facilities and equipment are prudently acquired and financed.
(2) Providers will obtain independent financing in accordance with a sound financial plan.
(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years.

(c) The use fee component of the capital return factor shall be limited by the lesser of:
(1) the original loan balance at the time of acquisition;
(2) eighty percent (80%) of historical cost of the facilities and equipment; or
(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall only be recognized when the interest rate is less than the original financing, and the interest rate on the refinancing shall not be allowable in excess of the interest rate limit established on the date the refinancing commitment was signed and the interest rate fixed by the lender and borrower.

(g) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (f).

(h) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(i) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of actual revenues. Interest on such loans shall only be recognized if the provider can demonstrate that such loans were reasonable and necessary in providing patient related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(j) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than patient care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(k) Loans from a related party must be identified and reported separately on the annual or historical financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid in accordance with an established repayment schedule.

(l) Use fee for variable interest rate mortgages will be calculated as follows:

(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.
(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).
(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.
(4) The use fee on the prospective rate is the amount determined in subdivision (3) plus or minus the variance in subdivision (2).

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-13; filed Aug 12, 1998, 2:32 p.m.: 22 IR 55; filed Sep 1, 2000, 2:10 p.m.: 24 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 2. 405 IAC 1-14.5-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.5-14 Allowable costs; capital return factor; computation of return on equity component

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 14. (a) For a provider with an initial interim rate resulting from:
(1) a change of provider status; or
(2) a new operation;
before the effective date of this rule, the return on equity shall be computed on the higher of twenty percent (20%) of the allowable historical cost of facilities and equipment, or actual equity in allowable facilities and equipment. Allowable historical cost of facilities and equipment is the lesser of the provider's actual historical cost of facilities and equipment or the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum allowable property basis per bed on the rate effective date.

(b) For a provider with an initial interim rate resulting from:
(1) a change of provider status; or
(2) a new operation;
on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

(d) The return on equity determined under this section shall be subject to the limitations under section 15(b) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-14; filed Aug 12, 1998, 2:32 p.m.: 22 IR 56; filed Sep 1, 2000, 2:10 p.m.: 24 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 3. 405 IAC 1-14.5-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.5-15 Allowable costs; capital return factor; use fee; depreciable life; property basis

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080
10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500
3/1/87	$21,900
9/1/87	$22,400
3/1/88	$22,600

9/1/88	$23,000
3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700
3/1/94	$26,000
9/1/94	$26,300
3/1/95	$26,500
9/1/95	$27,300
3/1/96	$27,700
9/1/96	$28,000
3/1/97	$28,300
9/1/97	$28,600

The schedule shall be updated semiannually, effective on March 1 and September 1 by the office, and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The capital return factor portion of a rate that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on:

(A) the maximum property basis per bed at the time of acquisition of each bed, plus one-half (½) of the difference between that amount and the maximum property basis per bed at the rate effective date times eighty percent (80%);

(B) the term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983; and

(C) the allowable interest rate is the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on:

(A) the allowable equity as established under section 14 of this rule; and

(B) a rate of return on equity that is the greater of United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be no greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Indiana Medicaid program shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.

(3) Travel costs.

(4) The costs of feasibility studies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-15; filed Aug 12, 1998, 2:32 p.m.: 22 IR 56; filed Sep 1, 2000, 2:10 p.m.: 24 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on August 22, 2002 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 5, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to the Medicaid reimbursement rule for HIV nursing facilities to change the index used in the calculation of the fair rental allowance from the United States Treasury 30 year bond to the United States Treasury 10 year bond. This change is being made because it was recently announced that the United States Treasury has stopped issuing the 30 year bond currently referenced in the rule. The 10 year bond is the new benchmark bond. There is no fiscal impact associated with this change.

Written comments regarding this change may be sent to the Office of Medicaid Policy and Planning, Indiana Government Center-South, 402 West Washington Street, Room W382, P.O. Box 7083, Indianapolis, Indiana 46204-2739 to the attention of Karen Smith Filler. Correspondence should be identified in the

following manner: COMMENTS RE: LSA DOCUMENT #02-144. Written comments received will be available for inspection at this address.

Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection. Also, copies of proposed amendments to the rule are now available along with copies of this public notice and may be inspected by contacting the director of the local County Division of Family and Children office, except in Marion County where public inspection may be made at the Indiana Government Center-South, 402 West Washington Street, Room W382, Indianapolis, Indiana.

John Hamilton
Secretary
Office of the Secretary of Family and Social Services

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #02-145

DIGEST

Adds 405 IAC 2-10 to provide for the placement of liens on the real property of certain Medicaid recipients. This rule implements IC 12-15-8.5 as added by P.L.178-2002 (HEA 1196). Effective 30 days after filing with the secretary of state.

405 IAC 2-10

SECTION 1. 405 IAC 2-10 IS ADDED TO READ AS FOLLOWS:

Rule 10. Lien Attachment and Enforcement

405 IAC 2-10-1 Definitions
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 1. The following definitions apply throughout this rule:

(1) "Disabled" is defined according to the criteria established under 42 U.S.C. 1382c.

(2) "Interest" means any equitable right, title, or interest in real property.

(3) "Lawfully residing in the home" means residing in the recipient's place of residence with the permission of the owners, or if under guardianship, the owner's legal guardian.

(4) "Medical institution" means a long term care facility, an intermediate care facility for the mentally retarded (ICF/MR), or other residential medical facility.

(5) "Permanently institutionalized" means an individual of any age who:

(A) is an inpatient in a nursing facility, ICF/MR facility, or other medical institution;

(B) is required, as a condition of receiving services in such institution under the state plan, to spend for costs of medical care all but a minimum amount of his income required for personal needs; and

(C) after notice and opportunity for a hearing, has been determined to have a medical condition of such severity that he or she cannot reasonably be expected to be discharged from the medical institution and returned to the noninstitutional home environment prior to death.

(6) "Real property" means land, including houses or immovable structures or objects attached permanently to the land in which a recipient has ownership rights and interests, including, but not limited to, the recipient's home.

(7) "Recipient's home" means the recipient's place of residence prior to institutionalization.

(8) "Residing in recipient's home on a continuous basis" means using the home as the principal place of residence.

(9) "TEFRA" means Tax Equity Fiscal Responsibility Act.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-1)

405 IAC 2-10-2 Recovery
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 2. The office shall seek reimbursement for Medicaid benefits paid on behalf of a recipient by either or both of the following methods:

(1) Filing and enforcing a lien in accordance with this rule.

(2) Filing and enforcing a claim against the estate of a deceased recipient in accordance with 405 IAC 2-8.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-2)

405 IAC 2-10-3 Criteria for instituting a TEFRA lien
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 3. (a) When the office in accordance with 42 U.S.C. 1396p determines that a Medicaid recipient who resides in a medical institution cannot reasonably be expected to be discharged and return home, the office may attach a lien on the Medicaid recipient's real property subject to the provisions of this rule and IC 12-15-8.5.

(b) The office may not obtain a lien on the recipient's home if any of the following people lawfully reside in the home of the institutionalized recipient:

(1) The recipient's spouse.
(2) The recipient's child who is less than twenty-one (21) years of age, blind, or disabled as defined in 42 U.S.C. 1382c.
(3) The recipient's sibling who:
(A) was residing in the recipient's home for a period of at least one (1) year immediately before the recipient's institutionalization; and
(B) has an ownership interest in the home.
(4) The recipient's parent.
(5) An individual, other than a paid caregiver, who:
(A) was continuously residing in the recipient's home for a period of at least two (2) years immediately prior to the date of the recipient's institutionalization; and
(B) establishes to the satisfaction of the office that the person provided care to the recipient enabling the recipient to reside in his or her home, delaying institutionalization.
(Office of the Secretary of Family and Social Services; 405 IAC 2-10-3)

405 IAC 2-10-4 Notice and opportunity for hearing
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 4. (a) The office shall notify the recipient or the recipient's authorized representative, if applicable, of its determination that the recipient is permanently institutionalized and not reasonably expected to return home and its intent to file a lien on recipient's real property. Notice must include an explanation of liens and their effect on an individual's ownership of real property.

(b) The office may file a lien not less than thirty-one (31) days following notice to recipient and after any hearing process has been completed, if a hearing is requested. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-4)*

405 IAC 2-10-5 Appeal
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 5. (a) A recipient or his or her designee may, within thirty (30) days after receipt of notice described in this rule, request an administrative hearing under this rule.

(b) Administrative hearings and appeals by Medicaid recipients are governed by the procedures and time limits set out in 405 IAC 1.1.

(c) Only one (1) appeal shall be afforded to a recipient, for each notice received in accordance with section 4 of this rule, notwithstanding the number of parcels owned by the recipient and identified in the notice. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-5)*

405 IAC 2-10-6 Lien attachment
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 6. (a) The office or its designee shall file a notice of lien with the recorder of the county in which the real property subject to the lien is located. The notice shall be filed prior to the recipient's death and shall include the following:
(1) Name and place of residence of the recipient against whom the lien is asserted.
(2) Legal description of the real property subject to the lien.

(b) The office shall file one (1) copy of the notice of lien with the county office of family and children in the county in which the real property is located. The county office shall retain a copy of the notice with the county office's records.

(c) The office shall provide one (1) copy of the notice of lien to the recipient or the recipient's authorized representative, if applicable, whose real property is affected. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-6)*

405 IAC 2-10-7 Effect of filing; duration
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 7. (a) From the date on which the notice of lien is recorded in the office of the county recorder, the notice of lien:
(1) constitutes due notice of a lien against the recipient or recipient's estate for any amount then recoverable and any amounts that become recoverable under this article; and
(2) gives a specific lien in favor of the office on the Medicaid recipient's interest in the real property.

(b) The lien continues from the date of filing until the lien:
(1) is satisfied;
(2) is released; or
(3) expires.
The lien automatically expires unless the office commences a foreclosure action not later than nine (9) months after the Medicaid recipient's death. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-7)*

405 IAC 2-10-8 Enforcement; foreclosure
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 8. (a) The office may not enforce a lien on the recipient's home under this rule if the following individuals are lawfully residing in the recipient's home and have resided there on a continuous basis since the recipient's date of admission to the medical institution:
(1) The recipient's child of any age who:
(A) resided in the recipient's home for at least twenty-four (24) months before the recipient was institutionalized; and

(B) establishes to the satisfaction of the office that he or she provided care to the recipient that enabled the recipient to reside in his or her home, delaying institutionalization.

(2) The recipient's sibling, who has resided in the recipient's home for a period of at least one (1) year immediately before the date of the recipient's admission to the medical institution.

(b) The office may not enforce a lien on the real property of the recipient under this rule as long as the recipient is survived by any of the following:

(1) Recipient's spouse.

(2) Recipient's child who is less than twenty-one (21) years of age, blind, or disabled as defined in this rule.

(3) The recipient's parent.

(c) If there is no condition present in subsection (a) or (b), the office, or its designee, may bring a proceeding in foreclosure on the lien or to make arbitration of the amount due on the lien as follows:

(1) If the real property or recipient's interest is sold during the lifetime of the recipient.

(2) Upon the death of the recipient.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-8)

405 IAC 2-10-9 Release; subordination

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 9. (a) The office shall release a lien obtained under this rule within (10) business days after the county office of family and children receives notice that the recipient is no longer institutionalized and is living in his or her home.

(b) A lien obtained under this rule is subordinate to the subsequent security interest of a financial institution as defined in IC 12-15-8.5 that loans money to the recipient, provided that the recipient is able to establish to the satisfaction of the office that the funds were used for any of the following purposes:

(1) The payment of taxes, insurance, maintenance, and repairs in order to preserve and maintain the recipient's real property.

(2) Operating capital for the operation of the recipient's farm, the recipient's business, or the recipient's real property that is income-producing.

(3) The payment of medical, dental, or optical expenses incurred by:

(A) the recipient;

(B) the recipient's spouse;

(C) the recipient's dependent parent; or

(D) a child less than twenty-one (21) years of age or who is blind or disabled.

(4) The reasonable costs and expenses for the support, maintenance, comfort, and education of the recipient's spouse, a dependent parent, or a child who is less than twenty-one (21) years of age or who is blind or disabled.

(c) If the real property subject to the lien is sold, the office shall release its lien at the closing, and the lien shall attach to the net proceeds of the sale. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-9)*

405 IAC 2-10-10 Exemption

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 10. A single exemption of one hundred twenty-five thousand dollars ($125,000) is afforded to an institutionalized recipient and applies to single or combined total interests of the recipient in all real property subject to a lien. This section expires January 1, 2008. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-10)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on September 11, 2002 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Government Center Auditorium, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed rules to provide for the placement of liens on the real property of certain Medicaid recipients. Written comments may be directed to the Indiana Government Center-South, 402 West Washington Street, Room W451, MS-27 Office of General Counsel, Attention: Maureen Bartolo, Indianapolis, Indiana, 46204. Correspondence should be identified in the following manner: "COMMENTS RE: PROPOSED RULE LSA Document #02-145: Medicaid Lien". Written comments received will be made available for public display at the above listed address of the Office of General Counsel.

Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

John Hamilton
Secretary
Office of the Secretary of Family and Social Services

TITLE 460 DIVISION OF DISABILITY, AGING, AND REHABILITATIVE SERVICES

Proposed Rule
LSA Document #02-46

DIGEST

Adds 460 IAC 6 concerning supported living services and supports for individuals with a developmental disability. The

proposed rule includes qualifications for approved providers of supported living services and supports; the process by which the bureau of developmental disabilities services (bureau) approves providers; the bureau's process for monitoring and ensuring compliance with provider standards and requirements; the rights of individuals receiving services; protection of individuals receiving services; and standards and requirements for approved providers of supported living services and supports. Effective 30 days after filing with the secretary of state.

460 IAC 6

SECTION 1. 460 IAC 6 IS ADDED TO READ AS FOLLOWS:

ARTICLE 6. SUPPORTED LIVING SERVICES AND SUPPORTS

Rule 1. Purpose

460 IAC 6-1-1 Purpose
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. The purpose of this article is to establish standards and requirements for the approval and monitoring of providers of supported living services and supports to individuals with a developmental disability. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-1-1)*

Rule 2. Applicability

460 IAC 6-2-1 Providers of services
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This article applies to the approval and monitoring of providers of supported living services or supported living supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-2-1)*

460 IAC 6-2-2 Rules applicable to all providers
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. This rule and 460 IAC 6-3 through 460 IAC 6-17 apply to all providers of supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-2-2)*

460 IAC 6-2-3 Rules applicable to specific providers
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. 460 IAC 6-18 through 460 IAC 6-35 apply to the providers of supported living services and supports specified in the respective rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-2-3)*

460 IAC 6-2-4 Conflict with Medicaid provisions
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. If any provision of this article is deemed to be in conflict with any federal or state statute, regulation, or rule that is specifically applicable to the Medicaid program, then such other statute, regulation, or rule shall supersede that part of this article in which the conflict is found. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-2-4)*

Rule 3. Definitions

460 IAC 6-3-1 Applicability of definitions
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. The definitions in this rule apply throughout this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-1)*

460 IAC 6-3-2 "Abuse" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. "Abuse" means the following:
(1) Intentional or willful infliction of physical injury.
(2) Unnecessary physical or chemical restraints or isolation.
(3) Punishment with resulting physical harm or pain.
(4) Sexual molestation, rape, sexual misconduct, sexual coercion, and sexual exploitation.
(5) Verbal or demonstrative harm caused by oral or written language, or gestures with disparaging or derogatory implications.
(6) Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-2)

460 IAC 6-3-3 "Adult protective services" or "APS" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-10-3; IC 12-11-1.1; IC 12-11-2.1

Sec. 3. "Adult protective services" or "APS" means the program established under IC 12-10-3. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-3)*

460 IAC 6-3-4 "Advocate" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) "Advocate" means a person who:
(1) assists an individual with decision making and self-determination; and
(2) is chosen by the individual or the individual's legal representative, if applicable.

(b) An advocate is not a legal representative unless legally appointed. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-4)*

460 IAC 6-3-5 "Applicant" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 5. "Applicant" means a natural person or entity who applies to the BDDS for approval to provide one (1) or more supported living services or supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-5)*

460 IAC 6-3-6 "BDDS" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1-1; IC 12-11-2.1

Sec. 6. "BDDS" means bureau of developmental disabilities services as created under IC 12-11-1.1-1. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-6)*

460 IAC 6-3-7 "Behavioral support plan" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 7. "Behavioral support plan" means a plan that addresses the behavioral support needs of an individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-7)*

460 IAC 6-3-8 "Behavioral support services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 8. "Behavioral support services" means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-8)*

460 IAC 6-3-9 "Case management services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 9. "Case management services" means services that enable an individual to receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-9)*

460 IAC 6-3-10 "Child protection services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 31-33

Sec. 10. "Child protection services" refers to child protection services established under IC 31-33. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-10)*

460 IAC 6-3-11 "Community-based sheltered employment services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 11. "Community-based sheltered employment services" means an agency-operated, work-oriented service consisting of on-going supervision of an individual while the individual is working. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-11)*

460 IAC 6-3-12 "Community education and therapeutic activities services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 12. "Community education and therapeutic activities services" means services in the community, such as the following:
(1) Vocational classes.
(2) Therapeutic horseback riding.
(3) Camps.
(4) Other public events for which there is a separate charge.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-12)

460 IAC 6-3-13 "Community habilitation and participation services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 13. "Community habilitation and participation services" means services outside of an individual's home that support learning and assistance in any of the following areas:
(1) Self-care.
(2) Sensory-motor development.
(3) Socialization.
(4) Daily living skills.
(5) Communication.
(6) Community living.
(7) Social skills.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-13)

460 IAC 6-3-14 "Community mental health center" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-7-2-38; IC 12-11-1.1; IC 12-11-2.1

Sec. 14. "Community mental health center" has the meaning set forth in IC 12-7-2-38. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-14)*

460 IAC 6-3-15 "Community mental retardation and other developmental disabilities centers" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-7-2-39; IC 12-11-1.1; IC 12-11-2.1

Sec. 15. "Community mental retardation and other

developmental disabilities centers" has the meaning set forth in IC 12-7-2-39. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-15)*

460 IAC 6-3-16 "Crisis assistance services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 16. "Crisis assistance services" means services designed to provide immediate access to short term, intensive services that are needed due to a behavioral or psychiatric emergency. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-16)*

460 IAC 6-3-17 "Developmental disabilities waiver ombudsman" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 12-11-13

Sec. 17. "Developmental disabilities waiver ombudsman" means the statewide waiver ombudsman described in IC 12-11-13. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-17)*

460 IAC 6-3-18 "Direct care staff" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 18. "Direct care staff" means a person, or an agent or employee of a provider entity, who provides hands-on services to an individual while providing any of the following services:

(1) Adult day services.
(2) Adult foster care services.
(3) Community-based sheltered employment services.
(4) Community education and therapeutic activities services.
(5) Community habilitation and participation services.
(6) Facility-based sheltered employment services.
(7) Prevocational services.
(8) Residential habilitation and support services.
(9) Respite care services.
(10) Supported employment services.
(11) Transportation services.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-18)

460 IAC 6-3-19 "Division" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-9-1-1; IC 12-11-1.1; IC 12-11-2.1

Sec. 19. (a) Except for purposes of 460 IAC 6-5-12, "division" means the division of disability, aging, and rehabilitative services created under IC 12-9-1-1.

(b) For purposes of 460 IAC 6-5-12, "division" means the wage and hour division of the United States Department of Labor. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-19)*

460 IAC 6-3-20 "Elopement" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 20. "Elopement" means that an individual leaves, without the authorization or consent of the appropriate provider, the level of supervision identified as appropriate for the individual in the individual's ISP. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-20)*

460 IAC 6-3-21 "Enhanced dental services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 21. "Enhanced dental services" means services provided to an individual with dental problems, which, if left untreated, would require the individual to be institutionalized. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-21)*

460 IAC 6-3-22 "Entity" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 22. "Entity" means any of the following:

(1) An association.
(2) A corporation.
(3) A limited liability company.
(4) A governmental entity.
(5) A partnership.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-22)

460 IAC 6-3-23 "Environmental modification supports" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 23. "Environmental modification supports" means a support that provides an individual with safe access into and within the individual's home and facilitates independence and self-reliance. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-23)*

460 IAC 6-3-24 "Exploitation" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 35-46-1-1

Sec. 24. "Exploitation" means:

(1) unauthorized use of the personal services, the property, or the identity of an individual; or
(2) any other type of criminal exploitation, including exploitation under IC 35-46-1-1;

for one's own profit or advantage or for the profit or advantage of another.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-24)

460 IAC 6-3-25 "Facility-based sheltered employment services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 25. "Facility-based sheltered employment services" means employment services provided to an individual that implement the individual's training goals and in which the individual is provided remuneration or other occupational activity. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-25)*

460 IAC 6-3-26 "Family and caregiver training services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 26. "Family and caregiver training services" means:
(1) training and education to instruct a parent, family member, or primary caregiver in the treatment regimens and use of equipment specified in an individual's ISP; and
(2) training to improve the ability of the parent, family member or primary caregiver to provide care to or for the individual.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-26)

460 IAC 6-3-27 "Health care coordination services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 27. "Health care coordination services" means medical coordination services to manage the health care needs of an individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-27)*

460 IAC 6-3-28 "Home health agency" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 16-27

Sec. 28. "Home health agency " means an agency licensed under IC 16-27. *(Division of Disability; Aging, and Rehabilitative Services; 460 IAC 6-3-28)*

460 IAC 6-3-29 "Hospital" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 16-27-1-2

Sec. 29. "Hospital" means a hospital licensed under IC 16-27-1-2. *(Division of Disability; Aging, and Rehabilitative Services; 460 IAC 6-3-29)*

460 IAC 6-3-30 "Individual" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 30. "Individual" means an individual with a developmental disability who has been determined eligible for services by a service coordinator pursuant to IC 12-11-2.1-1. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-30)*

460 IAC 6-3-31 "Individual community living budget" or "ICLB" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 31. "Individual community living budget" or "ICLB" means the format used by the BDDS to:
(1) uniformly account for all:
(A) service and living costs;
(B) sources and amounts of income and benefits; and
(C) other financial issues;
of an individual; and
(2) approve the allocation of state funding for specified services for the individual.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-31)

460 IAC 6-3-32 "Individualized support plan" or "ISP" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 32. "Individualized support plan" or "ISP" means a plan that establishes supports and strategies intended to accomplish the individual's long term and short term goals by accommodating the financial and human resources offered to the individual through paid provider services or volunteer services, or both, as designed and agreed upon by the individual's support team. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-32)*

460 IAC 6-3-33 "Integrated setting" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 33. "Integrated setting" means a setting in which at least fifty-one percent (51%) of the persons working in the setting are not disabled, except for the persons providing services under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-33)*

460 IAC 6-3-34 "Legal representative" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-10-13-3.3; IC 12-11-1.1; IC 12-11-2.1

Sec. 34 "Legal representative" has the meaning set forth in IC 12-10-13-3.3. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-34)*

460 IAC 6-3-35 "Music therapy services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 35. "Music therapy services" means services provided under this article for the systematic application of

music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-35)*

460 IAC 6-3-36 "Neglect" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 36. "Neglect" means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-36)*

460 IAC 6-3-37 "Nutritional counseling services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 37. "Nutritional counseling services" means services provided under this article by a licensed dietician. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-37)*

460 IAC 6-3-38 "Occupational therapy services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 38. "Occupational therapy services" means services provided under this article by a licensed occupational therapist. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-38)*

460 IAC 6-3-39 "Personal emergency response system supports" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 39. "Personal emergency response system supports" means an electronic communication device that allows an individual to communicate the need for immediate assistance in case of an emergency. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-39)*

460 IAC 6-3-40 "Physical therapy services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 40. "Physical therapy services" means services provided under this article by a licensed physical therapist. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-40)*

460 IAC 6-3-41 "Prevocational services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 41. "Prevocational services" means services aimed at preparing an individual for paid or unpaid employment, by teaching such concepts as compliance, attendance, task completion, problem solving, and safety. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-41)*

460 IAC 6-3-42 "Provider" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 42. "Provider" means a person or entity approved by the BDDS to provide the individual with agreed upon services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-42)*

460 IAC 6-3-43 "Psychological therapy services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 43. "Psychological therapy services" means services provided under this article by a licensed psychologist. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-43)*

460 IAC 6-3-44 "Recreational therapy services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 44. "Recreational therapy services" means services provided under this article and consisting of a medically approved recreational program to restore, remediate, or rehabilitate an individual in order to:

(1) improve the individual's functioning and independence; and

(2) reduce or eliminate the effects of an individual's disability.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-44)

460 IAC 6-3-45 "Rent and food for an unrelated live-in caregiver supports" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 45. "Rent and food for an unrelated live-in caregiver supports" means the additional cost an individual incurs for the room and board of an unrelated, live-in caregiver as provided for in the individual's ICLB. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-45)*

460 IAC 6-3-46 "Reportable incident" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 46. "Reportable incident" refers to incidents described in 460 IAC 6-9-5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-46)*

460 IAC 6-3-47 "Residential-based habilitation and support services" defined
Authority: IC 12-8-8-4; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 47. "Residential-based habilitation and support services" means services that are designed to ensure the

health, safety, and welfare of an individual, and assist in the acquisition, improvement, and retention of skills necessary for the individual to live successfully in the individual's own home. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-47)*

460 IAC 6-3-48 "Residential living allowance" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1-2; IC 12-11-2.1

Sec. 48. "Residential living allowance" means funds authorized by the BDDS services under IC 12-11-1.1-2(c) to cover the actual costs of room and board expenses as authorized in the individual's ICLB. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-48)*

460 IAC 6-3-49 "Residential living allowance management services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 49. "Residential living allowance management services" means services that assist an individual in managing the individual's residential living allowance supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-49)*

460 IAC 6-3-50 "Respite care services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 50. "Respite care services" means services provided to individuals unable to care for themselves that are furnished on a short term basis because of the absence or need for relief of those persons normally providing care. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-50)*

460 IAC 6-3-51 Secretary
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-8-1-2; IC 12-11-1.1; IC 12-11-2.1

Sec. 51. "Secretary" means the secretary of family and social services appointed under IC 12-8-1-2. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-51)*

460 IAC 6-3-52 "Specialized medical equipment and supplies supports" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 52. (a) "Specialized medical equipment and supplies supports" means devices, controls, or appliances that:
(1) enable an individual to increase the individual's abilities to:
(A) perform activities of daily living; or
(B) perceive or control the environment; or
(2) enhance an individual's ability to communicate.
(b) The term includes the following:
(1) Communication devices.
(2) Interpreter services.
(3) Items necessary for life support.
(4) Ancillary supplies and equipment necessary for the proper functioning of such items.
(5) Durable and nondurable medical equipment.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-52)

460 IAC 6-3-53 "Speech and language therapy services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 53. "Speech and language therapy services" means services provided by a licensed speech pathologist under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-53)*

460 IAC 6-3-54 "Support team" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 54. "Support team" means a team of persons, including an individual, the individual's legal representative, if applicable, the individual's providers, provider of case management services, and other persons who:
(1) are designated by the individual;
(2) know and work with the individual; and
(3) participate in the development and implementation of the individual's ISP.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-54)

460 IAC 6-3-55 "Supported employment services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 55. "Supported employment services" means services that support and enable an individual to secure and maintain paid employment if the individual is paid at or above the federal minimum wage. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-55)*

460 IAC 6-3-56 "Transportation services" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 56. "Transportation services" means services for the transportation of an individual in a vehicle by a provider approved under this article to provide transportation services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-56)*

460 IAC 6-3-57 "Transportation supports" defined
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 57. "Transportation supports" means supports, such as tickets and passes to ride on public transportation systems, that enable an individual to have transportation for access to the community. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-3-57)*

Rule 4. Types of Supported Living Services and Supports

460 IAC 6-4-1 Types of supported living services and supports

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. Supported living services and supports include the following:

(1) Adult day services.
(2) Adult foster care services.
(3) Behavioral support services.
(4) Case management services.
(5) Community-based sheltered employment services.
(6) Community education and therapeutic activity services.
(7) Community habilitation and participation services.
(8) Crisis assistance services.
(9) Enhanced dental services.
(10) Environmental modification supports.
(11) Facility-based sheltered employment services.
(12) Family and caregiver training services.
(13) Health care coordination services.
(14) Music therapy services.
(15) Nutritional counseling services.
(16) Occupational therapy services.
(17) Personal emergency response system supports.
(18) Physical therapy services.
(19) Prevocational services.
(20) Psychological therapy services.
(21) Recreational therapy services.
(22) Rent and food for unrelated live-in caregiver supports.
(23) Residential habilitation and support services.
(24) Residential living allowance and management services.
(25) Respite care services.
(26) Specialized medical equipment and supplies supports.
(27) Speech-language therapy services.
(28) Supported employment services.
(29) Transportation services.
(30) Transportation supports.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-4-1)

Rule 5. Provider Qualifications

460 IAC 6-5-1 Applicability

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-1)*

460 IAC 6-5-2 Adult day services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. To be approved to provide adult day services, an applicant shall be an approved adult day service provider for Medicaid waiver in-home services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-2)*

460 IAC 6-5-3 Adult foster care services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. To be approved to provide adult foster care services, an applicant shall:

(1) be an entity approved to provide supported living services under this article; and
(2) certify that, if approved, the entity will provide adult foster care services using only persons who meet the qualifications set out in 460 IAC 6-14-5.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-3)

460 IAC 6-5-4 Behavioral support services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-33-1-5.1

Sec. 4. (a) To be approved to provide behavioral support services as a Level 1 clinician, an applicant shall meet the following requirements:

(1) Be a licensed psychologist under IC 25-33 and have an endorsement as a health service provider in psychology pursuant to IC 25-33-1-5.1(c); or
(2) Have:
(A) at least a master's degree in:
(i) a behavioral science;
(ii) special education; or
(iii) social work; and
(B) evidence of five (5) years of experience in:
(i) working directly with individuals with developmental disabilities, including the devising, implementing, and monitoring of behavioral support plans; and
(ii) the supervision and training of others in the implementation of behavioral support plans.

(b) To be approved to provide behavioral support services as a Level 2 clinician, an applicant shall meet the following requirements:

(1) Either:
(A) have a master's degree in:
(i) psychology;
(ii) special education; or
(iii) social work; or

(B) meet all of the following requirements:

(i) Have a bachelor's degree in psychology.

(ii) Be employed as a behavioral consultant on or before September 30, 2001, by a provider of behavioral support services approved under this article.

(iii) Be working on a master's degree in psychology, special education, or social work.

(iv) By December 31, 2006, complete a master's degree in psychology, special education, or social work.

(2) Be supervised by a Level 1 clinician.

(c) To maintain approval as a behavioral support services provider, a behavioral support services provider shall:

(1) obtain annually at least ten (10) continuing education hours related to the practice of behavioral support:

(A) from a Category I sponsor as provided in 868 IAC 1.1-15; or

(B) as provided by the BDDS's behavioral support curriculum list; or

(2) be enrolled in:

(A) a master's level program in psychology, special education, or social work; or

(B) a doctoral program in psychology.

(d) For an entity to be approved to provide behavioral support services, the entity shall certify that, if approved, the entity shall provide Level 1 clinician behavioral support services or Level 2 clinician behavioral support services using only persons who meet the qualifications set out in this section.

(e) The provisions in subsection (b)(1)(B) expire on December 31, 2006. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-4)*

460 IAC 6-5-5 Case management services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-23-1

Sec. 5. (a) To be approved to provide case management services, an applicant shall meet the following requirements:

(1) Have a bachelor's degree, be a registered nurse licensed under IC 25-23-1, or be employed by the state in a PAT III position.

(2) Meet the experience requirements for a qualified mental retardation professional in 42 CFR 483.430(a).

(3) Complete a course of case management orientation that is approved by the BDDS.

(b) For an entity to be approved to provide case management services, the entity shall certify that, if approved, the entity will provide case management services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-5)*

460 IAC 6-5-6 Community-based sheltered employment services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 6. To be approved to provide community-based sheltered employment services, an applicant shall meet the following requirements:

(1) Be an entity.

(2) Be accredited by one (1) of following organizations:

(A) The Commission on Accreditation of Rehabilitation Facilities (CARF) or its successor.

(B) The Council on Quality and Leadership in Supports for People with Disabilities or its successor.

(C) The Joint Commission on Accreditation of Healthcare Organizations (JACHO) or its successor.

(D) The National Commission on Quality Assurance or its successor.

(E) An independent national accreditation organization approved by the secretary.

(3) Be a not-for-profit entity.

(4) Certify that, if approved, the entity will provide community-based sheltered employment services using only persons who meet the qualifications set out in 460 IAC 6-14-5.

(5) Not be a community mental health center.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-6)

460 IAC 6-5-7 Community education and therapeutic activity services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 7. To be approved to provide community education and therapeutic activities services, an applicant shall be approved under this article to provide either:

(1) residential habilitation and support services; or

(2) community habilitation and participation services.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-7)

460 IAC 6-5-8 Community habilitation and participation services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 8. (a) To be approved to provide community habilitation and participation services, an applicant shall meet the requirements for direct care staff set out in 460 IAC 6-14-5.

(b) For an entity to be approved to provide community habilitation and participation services, the entity shall certify that, if approved, the entity will provide community

habilitation and support services using only persons who meet the qualifications set out in 460 IAC 6-14-5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-8)*

460 IAC 6-5-9 Crisis assistance services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 9. To be approved to provide crisis assistance services, an applicant shall be approved to provide behavioral support services under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-9)*

460 IAC 6-5-10 Enhanced dental services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-14

Sec. 10. (a) To be approved to provide enhanced dental services, an applicant shall be a dentist licensed under IC 25-14.

(b) For an entity to be approved to provide enhanced dental services, the entity shall certify that, if approved, the entity will provide enhanced dental services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-10)*

460 IAC 6-5-11 Environmental modification supports provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 11. To be approved to provide environmental modification supports, an applicant shall:

(1) be licensed, certified, registered, or otherwise properly qualified under federal, state, or local laws applicable to the particular service that the applicant desires to perform; and

(2) certify that, if approved, the applicant will perform the services in compliance with federal, state, or local laws applicable to the type of modification being made.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-11)

460 IAC 6-5-12 Facility-based sheltered employment services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 12. To be approved to provide facility-based sheltered employment services, an applicant shall meet the following requirements:

(1) Be an entity.

(2) Be accredited, or provide proof of an application to seek accreditation, by one (1) of the following organizations:

(A) The Commission on Accreditation of Rehabilitation Facilities (CARF) or its successor.

(B) The Council on Quality and Leadership in Supports for People with Disabilities or its successor.

(C) The Joint Commission on Accreditation of Healthcare Organizations (JACHO) or its successor.

(D) The National Commission on Quality Assurance or its successor.

(E) An independent national accreditation organization approved by the secretary.

(3) Be a not-for-profit entity.

(4) Have sheltered workshop certification from the wage and hour division of the United States Department of Labor.

(5) Certify that, if approved, the entity will provide services using only persons who meet the qualifications set out in 460 IAC 6-14-5.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-12)

460 IAC 6-5-13 Family and caregiver training services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 13. To be approved to provide family and caregiver training services, an applicant shall be approved to provide either:

(1) community habilitation and participation services; or

(2) residential habilitation and support services;

under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-13)*

460 IAC 6-5-14 Heath care coordination services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-23-1

Sec. 14. (a) To be approved to provide health care coordination services, an applicant shall be either a registered nurse or licensed practical nurse under IC 25-23-1.

(b) For an entity to be approved to provide health care coordination services, the entity shall certify that, if approved, the entity will provide health care coordination services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-14)*

460 IAC 6-5-15 Music therapy services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 15. (a) To be approved to provide music therapy services, an applicant shall be certified by the National Association of Music Therapists.

(b) For an entity to be approved to provide music therapy services, the entity shall certify that, if approved, the entity will provide music therapy services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-15)*

460 IAC 6-5-16 Nutritional counseling services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-14.5

Sec. 16. (a) To be approved to provide nutritional counseling services, an applicant shall be a dietitian certified under IC 25-14.5.

(b) For an entity to be approved to provide nutritional counseling services, the entity shall certify that, if approved, the entity will provide nutritional counseling services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-16)*

460 IAC 6-5-17 Occupational therapy services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-23.5-1-5.5; IC 25-23.5-5

Sec. 17. (a) To be approved to provide occupational therapy services as an occupational therapist, an applicant shall be an occupational therapist certified under IC 25-23.5.

(b) To be approved to provide occupational therapy services as an occupational therapy assistant, an applicant shall be certified under IC 25-23.5-5.

(c) To be approved to provide occupational therapy services as an occupational therapy aide, an applicant shall meet the requirements of IC 25-23.5-1-5.5 and 844 IAC 10-6.

(d) For an entity to be approved to provide occupational therapy services, the entity shall certify that, if approved, the entity will provide occupational therapy services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-17)*

460 IAC 6-5-18 Personal emergency response system supports provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 18. To be approved to provide personal emergency response system supports, an applicant shall:

(1) be licensed, certified, registered, or otherwise properly qualified under federal, state, or local laws applicable to the particular service that the applicant desires to perform; and

(2) certify that, if approved, the applicant will perform the services in compliance with federal, state, or local laws applicable to a personal emergency response system. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-18)*

460 IAC 6-5-19 Physical therapy services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-27-1

Sec. 19. (a) To be approved to provide physical therapy services as a physical therapist, an applicant shall be a physical therapist licensed under IC 25-27-1.

(b) To be approved to provide physical therapy services as a physical therapist's assistant, an applicant shall be certified under IC 25-27-1.

(c) For an entity to be approved to provide physical therapy services, the entity shall certify that, if approved, the entity will provide physical therapy services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-19)*

460 IAC 6-5-20 Prevocational services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 20. (a) To be approved to provide prevocational services, an applicant shall meet the requirements for direct care staff set out in 460 IAC 6-14-5.

(b) For an entity to be approved to provide prevocational services, the entity shall certify that, if approved, the entity will provide prevocational services using only persons who meet the qualification set out in 460 IAC 6-14-5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-20)*

460 IAC 6-5-21 Psychological therapy services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-22.5; IC 25-23.6; IC 25-33-1

Sec. 21. (a) To be approved to provide psychological therapy services, an applicant shall be:

(1) a psychologist licensed under IC 25-33-1;
(2) a marriage and family therapist licensed under IC 25-23.6, IC 25-22.5, or IC 25-33;
(3) a clinical social worker licensed under IC 25-23.6; or
(4) a mental health counselor licensed under IC 25-23.6.

(b) For an entity to be approved to provide psychological therapy services, the entity shall certify that, if approved, the entity will provide psychological therapy services using

only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-21)*

460 IAC 6-5-22 Recreational therapy services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 22. (a) To be approved to provide recreational therapy services, an applicant shall be certified by the national council for therapeutic recreation certification.

(b) To be approved to provide recreational therapy services, an entity shall certify that, if approved, the entity will provide recreational therapy services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-22)*

460 IAC 6-5-23 Rent and food for unrelated live-in caregiver supports provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 23. To be approved to provide rent and food for unrelated live-in caregiver supports, an applicant shall be approved to provide:

(1) community habilitation and participation services; or

(2) residential habilitation and support services;

under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-23)*

460 IAC 6-5-24 Residential habilitation and support services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 24. (a) To be approved to provide residential habilitation and support services, an applicant shall meet the requirements for direct care staff set out in 460 IAC 6-14-5.

(b) In order an entity to be approved to provide residential habilitation and support services, the entity shall certify that, if approved, the entity will provide residential habilitation and support services using only persons who meet the qualifications set out in 460 IAC 6-14-5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-24)*

460 IAC 6-5-25 Residential living allowance and management services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 25. To be approved to provide residential living allowance and management services, an applicant shall be approved to provide either:

(1) residential habilitation and support services; or

(2) community habilitation and participation services;

under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-25)*

460 IAC 6-5-26 Respite care services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 26. (a) To be approved to provide respite care services, an applicant shall meet the requirements for direct care staff set out in 460 IAC 6-14-5.

(b) For an entity to be approved to provide respite care services, the entity shall meet both of the following requirements:

(1) Be one (1) of the following types of entities:

(A) A home health agency.

(B) An approved adult day service provider under this article.

(C) An entity providing residential services to unrelated individuals.

(2) Certify that, if approved, the entity will provide respite care services using only persons who meet the direct care staff qualifications set out in 460 IAC 6-14-5.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-26)

460 IAC 6-5-27 Specialized medical equipment and supplies supports provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 27. To be approved to provide specialized medical equipment and supplies supports, an applicant shall:

(1) be licensed, certified, registered, or otherwise properly qualified under federal, state, or local laws applicable to the particular service that the applicant desires to perform; and

(2) certify that, if approved, the applicant will perform the services in compliance with federal, state, or local laws applicable to the type of equipment and supplies being provided.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-27)

460 IAC 6-5-28 Speech-language therapy services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 25-35.6-1-2

Sec. 28. (a) To be approved to provide speech-language therapy services as a speech-language pathologist, an applicant shall be a speech-language pathologist licensed under IC 25-35.6.

(b) To be approved to provide speech language therapy services as a speech-language pathology aide, an applicant shall be:

(1) a speech-language pathology aide as defined in IC 25-35.6-1-2; and

(2) registered pursuant to 880 IAC 1-2.

(c) For an entity to be approved to provide speech-language therapy services, the entity shall certify that, if approved, the entity will provide speech-language therapy services using only persons who meet the qualifications set out in this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-28)*

460 IAC 6-5-29 Supported employment services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 29. To be approved to provide supported employment services, an applicant shall meet the following requirements:

(1) Be accredited by, or provide proof of an application to seek accreditation from, one (1) of the following organizations:

(A) The Commission on Accreditation of Rehabilitation Facilities (CARF) or its successor.

(B) The Council on Quality and Leadership in Supports for People with Disabilities or its successor.

(C) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or its successor.

(D) The National Commission on Quality Assurance or its successor.

(E) An independent national accreditation organization approved by the secretary.

(2) Certify that, if approved, the applicant will provide services using only persons who meet the qualifications set out in 460 IAC 6-14-5.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-29)

460 IAC 6-5-30 Transportation services provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 12-17.2-2-4

Sec. 30. (a) To be approved to provide transportation services, an applicant shall be one (1) of the following:

(1) A community mental retardation and other developmental disabilities centers.

(2) A community mental health center.

(3) A child care center licensed pursuant to IC 12-17.2-2-4.

(4) Otherwise approved under this rule.

(b) To be approved to provide transportation services, an applicant shall certify that, if approved, transportation services will be provided using only persons having a valid Indiana:

(1) operator's license;

(2) chauffeur's license;

(3) public passenger chauffeur's license; or

(4) commercial driver's license;

issued to the person by the Indiana bureau of motor vehicles to drive the type of motor vehicle for which the license was issued. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-30)*

460 IAC 6-5-31 Transportation supports provider qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 31. To be approved to provide transportation supports, an applicant shall be otherwise approved to provide supported living services under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-5-31)*

Rule 6. Application and Approval Process

460 IAC 6-6-1 Applicability

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-6-1)*

460 IAC 6-6-2 Initial application

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. To receive initial approval as a supported living services or supports provider, an applicant shall submit the following for each supported living service or support for which the applicant is seeking to be an approved provider:

(1) An application on a form prescribed by the BDDS.

(2) Evidence that the provider meets the qualifications for each supported living service or support that the provider is seeking to be approved to provide as specified in this article.

(3) Supporting documents specified on the application form to demonstrate the applicant's programmatic, financial and managerial ability to provide supported living services or supports as set out in this article.

(4) A written and signed statement that the applicant will comply with the provisions of this article.

(5) A written and signed statement that the applicant will provide services to an individual as set out in the individual's ISP.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-6-2)

460 IAC 6-6-3 Action on application
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 4-21.5; IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) The BDDS shall determine whether an applicant meets the requirements under this article.

(b) Upon review of an initial application, the BDDS shall either:
(1) approve the applicant for a period not to exceed (3) years; or
(2) deny approval to an applicant that does not meet the approval requirements of this article.

(c) The BDDS shall notify an applicant in writing of the BDDS's determination within sixty (60) days of submission of a completed application.

(d) If an applicant is adversely affected or aggrieved by the BDDS's determination, the applicant may request administrative review of the determination. Such request shall be made in writing and filed with the director of the division within fifteen (15) days after the applicant receives written notice of the BDDS's determination. Administrative review shall be conducted pursuant to IC 4-21.5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-6-3)*

460 IAC 6-6-4 Additional approvals; community residential facilities council
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 12-28-5-11

Sec. 4. Before beginning to provide supported living services or supports under this article, a provider shall also be approved by the community residential facilities council pursuant to IC 12-28-5-11. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-6-4)*

460 IAC 6-6-5 Renewal of approval
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 4-21.5; IC 12-11-1.1; IC 12-11-2.1

Sec. 5. (a) A provider of supported living services or supports shall file a written request for renewal of the BDDS's approval at least ninety (90) days prior to expiration of the BDDS's previous approval.

(b) Upon receiving a request for renewal of approved status, the BDDS shall determine whether a provider continues to meet the requirements of this article.

(c) The BDDS's determination on renewal of approval shall be based on verification that:
(1) the provider's operations have been surveyed either:
(A) within the preceding twelve (12) months; or
(B) as part of the renewal process; and
(2) there are no outstanding issues that seriously endanger the health or safety of an individual receiving services from the provider.

(d) In considering a request for the renewal of approval, the BDDS shall either:
(1) approve the applicant for a period not to exceed three (3) years; or
(2) deny approval to an applicant that does not meet the approval requirements of this article.

(e) The BDDS shall notify a provider in writing of the BDDS's determination at least thirty (30) days prior to the expiration of the provider's approval under this section.

(f) If a provider is adversely affected or aggrieved by the BDDS's determination, the provider may request administrative review of the determination. The request shall be made in writing and filed with the director of the division within fifteen (15) days after the provider receives written notice of the determination. Administrative review shall be conducted pursuant to IC 4-21.5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-6-5)*

460 IAC 6-6-6 Application to provide additional services
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 6. (a) A provider seeking approval to provide an additional supported living service or support shall comply with section 2 of this rule.

(b) Approval to provide additional supported living services or supports shall be granted by the BDDS only if:
(1) the provider's operations have been surveyed either:
(A) within the preceding twelve (12) months; or
(B) as part of the approval process to provide additional services; and
(2) there are no outstanding issues that seriously endanger the health or safety of an individual.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-6-6)

Rule 7. Monitoring; Sanctions; Administrative Review

460 IAC 6-7-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-7-1)*

460 IAC 6-7-2 Monitoring; corrective action
Authority: IC 12-8-4-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) The BDDS shall monitor compliance with the requirements of this article at the following times:

(1) At least annually.

(2) Upon receiving a complaint or report alleging a provider's noncompliance with the requirements of this article.

(b) The BDDS shall monitor compliance with the requirements of this article through any of the following means:

(1) Requesting and obtaining information from the provider.

(2) Site inspections.

(3) Meeting with an individual or the individual's legal representative as applicable.

(4) Review of provider records and the records of an individual.

(5) Follow-up inspection as is reasonably necessary to determine compliance after the BDDS has requested a corrective action plan.

(c) After any site inspection, the BDDS shall issue a written report. The report shall:

(1) be prepared by the BDDS or its designee;

(2) document the findings made during monitoring;

(3) identify necessary corrective action;

(4) identify the time period in which a corrective action plan shall be completed by the provider;

(5) identify any documentation needed from the provider to support the provider's completion of the corrective action plan; and

(6) be submitted to the provider.

(d) A provider shall:

(1) complete a corrective action plan to the reasonable satisfaction of the BDDS or its designee within the time period identified in the corrective action plan, or within such longer time period agreed to by the BDDS or its designee and the provider;

(2) notify the BDDS or its designee upon the completion of a corrective action plan; and

(3) provide the BDDS or its designee with any requested documentation.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-7-2)

460 IAC 6-7-3 Effect of noncompliance; notice

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 4-21.5; IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) If a provider does not comply with the requirements of this article and does not complete a corrective action plan to the reasonable satisfaction of the BDDS or its designee within the time allowed, the BDDS shall not authorize:

(1) the continuation of services to an individual or individuals by the provider, if the services do not comply with this article; or

(2) the receipt of services by individuals not already receiving services from the provider at the time the determination is made that the provider did not implement a corrective action plan to the reasonable satisfaction of the BDDS or its designee.

(b) After an acceptable corrective plan of action has been submitted to the BDDS, the BDDS shall monitor the provider's compliance with the corrective action plan. If the BDDS determines that the provider has not implemented the corrective plan of action, the BDDS shall not authorize:

(1) the continuation of services to an individual or individuals by the provider, if the services do not comply with this article; or

(2) the receipt of services by individuals not already receiving services from the provider at the time the determination is made that the provider did not submit a corrective action plan to the reasonable satisfaction of the BDDS or its designee.

(c) The BDDS shall give written notice of the BDDS's action under subsection (a) or (b) to:

(1) the provider;

(2) the individual receiving service from the provider; and

(3) the individual's legal representative if applicable.

(d) The written notice under subsection (c) shall include the following:

(1) The requirements of this article with which the provider has not complied.

(2) The effective date, with at least thirty (30) days' notice, of the BDDS's action under subsection (a).

(3) The need for planning to obtain services that comply with this article for an individual or individuals.

(4) The provider's right to seek administrative review of the BDDS's action.

(Division of Disability, Aging and Rehabilitative Services; 460 IAC 6-7-3)

460 IAC 6-7-4 Serious endangerment of individual's health and safety

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 4-21.5; IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) If a provider's noncompliance with this article seriously endangers the health or safety of an individual such that an emergency exists, as determined by the BDDS or its designee, the BDDS may enter an order for any of the following:

(1) Termination of continued authorization for the provider to serve any individual whose health or safety is being seriously endangered.

(2) Denial of authorization for the receipt of services by individuals not already receiving services from the provider at the time the BDDS determines that a provider's noncompliance with this article endangers the health or safety of an individual.

(3) Termination of continued authorization for the provider to provide any services under this article.

(b) Any action taken pursuant to subsection (a) shall remain in effect until such time as the BDDS or its designee determines that the provider's noncompliance with this article is no longer endangering the health and safety of an individual.

(c) The BDDS shall give written notice of an order under subsection (a) to:
(1) the provider;
(2) the individual receiving service from the provider; and
(3) the individual's legal representative as applicable.

(d) The written notice under subsection (a) shall include the following:
(1) The requirements of this article with which the provider has not complied.
(2) A brief statement of the facts and the law leading to the BDDS's determination that an emergency exists.
(3) The need to immediately obtain services that comply with this article for an individual or individuals.
(4) The provider's right to seek administrative review of the BDDS's action.

(e) The order issued under subsection (a) shall expire:
(1) on the date the BDDS determines that an emergency no longer exists; or
(2) in ninety (90) days;
whichever is less.

(f) During the pendency of any related proceedings under IC 4-21.5, the BDDS may renew an emergency order for successive ninety (90) day periods. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-7-4)*

460 IAC 6-7-5 Revocation of approval
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 5. The BDDS shall revoke the approval of a provider under this rule for the following reasons:
(1) The provider's repeated noncompliance with this article.
(2) The provider's continued noncompliance with this article.
(3) The provider's noncompliance with this article that seriously endangers the health or safety of an individual.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-7-5)

460 IAC 6-7-6 Administrative review
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 4-21.5; IC 12-11-1.1; IC 12-11-2.1

Sec. 6. (a) To qualify for administrative review of an action or determination of the BDDS under this rule, a provider shall file a written petition for review that does the following:
(1) States facts demonstrating that the provider is:
(A) a provider to whom the action is specifically directed;
(B) aggrieved or adversely affected by the action; or
(C) entitled to review under any law.
(2) Is filed with the director of the division of disability, aging, and rehabilitative services within fifteen (15) days after the provider receives notice of the agency action or determination.

(b) Administrative review shall be conducted in accordance with IC 4-21.5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-7-6)*

Rule 8. Rights of Individuals

460 IAC 6-8-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-8-1)*

460 IAC 6-8-2 Constitutional and statutory rights
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 12-27

Sec. 2. (a) A provider shall ensure that an individual's rights as guaranteed by the Constitution of the United States and the Constitution of Indiana are not infringed upon.

(b) A provider shall ensure that:
(1) an individual's rights as set out in IC 12-27 are not infringed upon; and
(2) an individual has the ability to exercise those rights as provided in IC 12-27.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-8-2)

460 IAC 6-8-3 Promoting the exercise of rights
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. To protect an individual's rights and enable an individual to exercise the individual's rights, a provider shall do the following:
(1) Provide an individual with humane care and protection from harm.
(2) Provide services that:
(A) are meaningful and appropriate; and
(B) comply with:
(i) standards of professional practice;
(ii) guidelines established by accredited professional organizations if applicable; and
(iii) budgetary constraints;
in a safe, secure, and supportive environment.

(3) Obtain written consent from an individual, or the individual's legal representative, if applicable, before releasing information from the individual's records unless the person requesting release of the records is authorized by law to receive the records without consent.
(4) Process and make decisions regarding complaints filed by an individual within two (2) weeks after the provider receives the complaint.
(5) Inform an individual, in writing and in the individual's usual mode of communication, of:
(A) the individual's constitutional and statutory rights using a form approved by the BDDS; and
(B) the complaint procedure established by the provider for processing complaints.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-8-3)

Rule 9. Protection of an Individual

460 IAC 6-9-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-9-1)*

460 IAC 6-9-2 Adoption of policies and procedures to protect individuals
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1-1; IC 12-11-2.1

Sec. 2. (a) A provider shall adopt written policies and procedures regarding the requirements of sections 3 and 4 of this rule.

(b) A provider shall require the provider's employees or agents to be familiar with and comply with the policies and procedures required by subsection (a).

(c) Beginning on the date services for an individual commence and at least one (1) time a year thereafter, a provider shall inform:
(1) the individual, in writing and in the individual's usual mode of communication;
(2) the individual's parent, if the individual is less than eighteen (18) years of age, or if the individual's parent is the individual's legal representative; and
(3) the individual's legal representative if applicable;
of the policies and procedures adopted pursuant to this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-9-2)*

460 IAC 6-9-3 Prohibiting violations of individual rights
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) A provider shall not:
(1) abuse, neglect, exploit, or mistreat an individual; or
(2) violate an individual's rights.

(b) A provider who delivers services through employees or agents shall adopt policies and procedures that prohibit:
(1) abuse, neglect, exploitation, or mistreatment of an individual; or
(2) violation of an individual's rights.

(c) Practices prohibited under this section include the following:
(1) Corporal punishment inflicted by the application of painful stimuli to the body, which includes:
(A) forced physical activity;
(B) hitting;
(C) pinching;
(D) the application of painful or noxious stimuli;
(E) the use of electric shock; or
(F) the infliction of physical pain.
(2) Seclusion by placing an individual alone in a room or other area from which exit is prevented.
(3) Verbal abuse, including screaming, swearing, name-calling, belittling, or other verbal activity that may cause damage to an individual's self-respect or dignity.
(4) A practice that denies an individual any of the following without a physician's order:
(A) Sleep.
(B) Shelter.
(C) Food.
(D) Drink.
(E) Physical movement for prolonged periods of time.
(F) Medical care or treatment.
(G) Use of bathroom facilities.
(5) Work or chores benefiting others without pay unless:
(A) the provider has obtained a certificate from the United States Department of Labor authorizing the employment of workers with a disability at special minimum wage rates;
(B) the services are being performed by an individual in the individual's own residence as a normal and customary part of housekeeping and maintenance duties; or
(C) an individual desires to perform volunteer work in the community.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-9-3)

460 IAC 6-9-4 Systems for protecting individuals
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) Except as specified in this section, this section applies to all providers of supported living services and supports.

(b) A provider shall require that at regular intervals, as specified by the individual's ISP, the individual be informed of the following:

(1) The individual's medical condition.

(2) The individual's developmental and behavioral status.

(3) The risks of treatment.

(4) The individual's right to refuse treatment.

(c) Except for providers of:

(1) occupational therapy services;

(2) physical therapy services;

(3) music therapy services; and

(4) speech-language therapy services;

a provider shall establish a protocol for ensuring that an individual is free from unnecessary medications and physical restraints.

(d) Except for providers of:

(1) occupational therapy services;

(2) physical therapy services;

(3) music therapy services; and

(4) speech-language therapy services;

a provider shall establish a system to reduce an individual's dependence on medications and physical restraints.

(e) A provider shall establish a system to ensure that an individual has the opportunity for personal privacy.

(f) A provider shall establish a system to:

(1) ensure that an individual is not compelled to perform services for a provider; and

(2) provide that, if an individual works voluntarily for a provider, the individual is compensated:

(A) at the prevailing wage for the job; and

(B) commensurate with the individual's abilities;

unless the provisions of section 3(c)(5) of this rule are met.

(g) A provider shall establish a system that ensures that an individual has:

(1) the opportunity to communicate, associate, and meet privately with persons of the individual's choosing;

(2) the means to send and receive unopened mail; and

(3) access to a telephone with privacy for incoming and outgoing local and long distance calls at the individual's expense.

(h) A provider shall establish a system for providing an individual with the opportunity to participate in social, religious, and community activities.

(i) A provider shall establish a system that ensures that an individual has the right to retain and use appropriate personal possessions and clothing.

(j) A provider shall establish a system for protecting an individual's funds and property from misuse or misappropriation.

(k) A provider shall establish a protocol specifying the responsibilities of the provider for:

(1) conducting an investigation; or

(2) participating in an investigation;

of an alleged violation of an individual's rights or a reportable incident. The system shall include taking all immediate necessary steps to protect an individual who has been the victim of abuse, neglect, exploitation, or mistreatment from further abuse, neglect, exploitation, or mistreatment.

(l) A provider shall establish a system providing for:

(1) administrative action against;

(2) disciplinary action against; and

(3) dismissal of;

an employee or agent of the provider, if the employee or agent is involved in the abuse, neglect, exploitation, or mistreatment of an individual or a violation of an individual's rights.

(m) A provider shall establish a written procedure for employees or agents of the provider to report violations of the provider's policies and procedures to the provider.

(n) A provider shall establish a written procedure for the provider or for an employee or agent of the provider for informing:

(1) adult protective services or child protection services, as applicable;

(2) an individual's legal representative, if applicable;

(3) any person designated by the individual; and

(4) the provider of case management services to the individual;

of a situation involving the abuse, neglect, exploitation, mistreatment of an individual, or the violation of an individual's rights.

(o) A provider shall establish a written protocol for reporting reportable incidents to the BDDS as required by section 5 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-9-4)*

460 IAC 6-9-5 Incident reporting

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 5. (a) An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS:

(1) Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to adult protective services or child protection services as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider.

(2) Death of an individual. A death shall also be reported to adult protective services or child protection services as applicable.
(3) A service delivery site that compromises the health and safety of an individual while the individual is receiving services from the following causes:
(A) A significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, fire alarm, or sprinkler system.
(B) Environmental or structural problems associated with a habitable site that compromise the health and safety of an individual, including:
(i) inappropriate sanitation;
(ii) serious lack of cleanliness;
(iii) rodent or insect infestation;
(iv) structural damage; or
(v) damage caused by flooding, tornado, or other acts of nature.
(4) Fire resulting in relocation, personal injury, property loss, or other health and safety concerns to or for an individual receiving services.
(5) Elopement of an individual.
(6) Suspected or actual criminal activity by:
(A) a staff member, employee, or agent of a provider; or
(B) an individual receiving services.
(7) An event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services.
(8) Admission of an individual to a nursing facility, including respite stays.
(9) Injury to an individual when the origin or cause of the injury is unknown.
(10) A significant injury to an individual, including:
(A) a fracture;
(B) a burn greater than first degree;
(C) choking that requires intervention; or
(D) contusions or lacerations.
(11) An injury that occurs while an individual is restrained.
(12) A medication error, except for refusal to take medications, that jeopardizes an individual's health and safety, including the following:
(A) Medication given that was not prescribed or ordered for the individual.
(B) Failure to administer medication as prescribed, including:
(i) incorrect dosage;
(ii) missed medication; and
(iii) failure to give medication at the appropriate time.
(13) Inadequate staff support for an individual, including inadequate supervision, with the potential for:
(A) significant harm or injury to an individual; or
(B) death of an individual.
(14) Inadequate medical support for an individual, including failure to obtain:
(A) necessary medical services;
(B) routine dental or physician services; or
(C) medication timely resulting in missed medications.

(b) An incident described in subsection (a) shall be reported by a provider or an employee or agent of a provider who:
(1) is providing services to the individual at the time of the incident; or
(2) becomes aware of or receives information about an alleged incident.

(c) An initial report regarding an incident shall be submitted within twenty-four (24) hours of:
(1) the occurrence of the incident; or
(2) the reporter becoming aware of or receiving information about an incident.

(d) A provider shall submit a follow-up report concerning the incident on the BDDS's follow-up incident report form at the following times:
(1) Within seven (7) days of the date of the initial report.
(2) Every seven (7) days thereafter until the incident is resolved.

(e) A provider is not required to submit a follow-up report if both of the following requirements are met:
(1) The provider states on an incident report that no follow-up report is necessary.
(2) The BDDS does not inform the provider that a follow-up report is necessary.

(f) All information required to be submitted to the BDDS shall also be submitted to the provider of case management services to the individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-9-5)*

460 IAC 6-9-6 Transfer of individual's records upon change of provider

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 6. (a) If an individual changes providers for any supported living service or support, the new provider shall:
(1) discuss with the individual the new provider's need to obtain a copy of the previous provider's records and files concerning the individual;
(2) provide the individual with a written form used to authorize the previous provider's release of a copy of the records and files concerning the individual to the new provider; and
(3) request the individual to sign the release form.

(b) Upon receipt of a written release signed by the individual, a provider shall forward a copy of all of the individual's records and files to the new provider no later than seven (7) days after receipt of the written release

signed by the individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-9-6)*

Rule 10. General Administrative Requirements for Providers

460 IAC 6-10-1 Applicability

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-1)*

460 IAC 6-10-2 Documentation of approvals

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. A provider shall maintain documentation that the BDDS has approved the provider for each service provided. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-2)*

460 IAC 6-10-3 Compliance with laws

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. A provider shall comply with all applicable state and federal statutes, rules, regulations, and requirements, including all applicable provisions of the federal Americans with Disabilities Act (ADA), 42 U.S.C. 12001 et seq. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-3)*

460 IAC 6-10-4 Compliance with state Medicaid plan; Medicaid waivers

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. A provider shall comply with the provisions of:

(1) the state Medicaid plan; and

(2) any Medicaid waiver applicable to the provider's services.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-4)

460 IAC 6-10-5 Documentation of criminal histories

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1; IC 16-27-2-5; IC 31-33-22-1; IC 35-42-1; IC 35-42-4; IC 35-43-4; IC 35-46-1-12; IC 35-46-1-13

Sec. 5. (a) A provider shall obtain a limited criminal history from the Indiana central repository for criminal history information from each employee, officer, or agent involved in the management, administration, or provision of services.

(b) The limited criminal history shall verify that the employee, officer, or agent has not been convicted of the following:

(1) A sex crime (IC 35-42-4).

(2) Exploitation of an endangered adult (IC 35-46-1-12).

(3) Failure to report:

(A) battery, neglect, or exploitation of an endangered adult (IC 35-46-1-13); or

(B) abuse or neglect of a child (IC 31-33-22-1).

(4) Theft (IC 35-43-4), if the person's conviction for theft occurred less than ten (10) years before the person's employment application date, except as provided in IC 16-27-2-5(a)(5).

(5) Murder (IC 35-42-1-1).

(6) Voluntary manslaughter (IC 35-42-1-3).

(7) Involuntary manslaughter (IC 35-42-1-4).

(8) Felony battery.

(9) A felony offense relating to a controlled substance.

(c) A provider shall have a report from the state nurse aid registry of the Indiana state department of health verifying that each employee or agent involved in the management, administration, and provision of services has not had a finding entered into the state nurse aide registry. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-5)*

460 IAC 6-10-6 Provider organizational chart

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 6. (a) A provider shall maintain a current organizational chart, including parent organizations and subsidiary organizations.

(b) Upon request, a provider shall supply the BDDS with a copy of the chart described in subsection (a). *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-6)*

460 IAC 6-10-7 Collaboration and quality control

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 7. (a) A provider for an individual shall collaborate with the individual's other service providers to provide services to the individual consistent with the individual's ISP.

(b) A provider for an individual shall give the individual's provider of case management services access to the provider's quality assurance and quality improvement procedures.

(c) If a provider administers medication to an individual, the provider for the individual shall implement the medication administration system designed by the individual's provider responsible for medication administration.

(d) If applicable, a provider for an individual shall implement the seizure management system designed by the individual's provider responsible for seizure management.

(e) If applicable, a provider for an individual shall implement the health-related incident management system designed by the individual's provider responsible for health-related incident management.

(f) If applicable, a provider for an individual shall implement the behavioral support plan designed by the individual's provider of behavioral support services.

(g) If an individual dies, a provider shall cooperate with the provider responsible for conducting an investigation into the individual's death pursuant to 460 IAC 6-25-9. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-7)*

460 IAC 6-10-8 Resolution of disputes

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 4-21.5; IC 12-11-1.1; IC 12-11-2.1

Sec. 8. (a) If a dispute arises between or among providers, the dispute resolution process set out in this section shall be implemented.

(b) The resolution of a dispute shall be designed to address an individual's needs.

(c) The parties to the dispute shall attempt to resolve the dispute informally through an exchange of information and possible resolution.

(d) If the parties are not able to resolve the dispute:
(1) each party shall document:
(A) the issues in the dispute;
(B) their positions; and
(C) their efforts to resolve the dispute; and
(2) the parties shall refer the dispute to the individual's support team for resolution.

(e) The parties shall abide by the decision of the individual's support team.

(f) If:
(1) an individual's support team cannot resolve the matter; and
(2) the provider of case management services to the individual is not a party to the dispute;
the provider of case management services to the individual shall resolve the matter.

(g) The parties shall abide by the decision of the provider of case management services to the individual.

(h) If:
(1) the individual disagrees with the decision of the provider of case management services or the individual's support team cannot resolve the matter; and
(2) the provider of case management services to the individual is a party to the dispute;
then the parties shall refer the matter to the individual's service coordinator for resolution of the dispute.

(i) The service coordinator shall give the parties notice of the service coordinator's decision pursuant to IC 4-21.5.

(j) Any party adversely affected or aggrieved by the service coordinator's decision may request administrative review of the service coordinator's decision within fifteen (15) days after the party receives written notice of the service coordinator's decision.

(k) Administrative review shall be conducted pursuant to IC 4-21.5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-8)*

460 IAC 6-10-9 Automation standards

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 9. A provider shall comply with all automation standards and requirements prescribed by the applicable funding agency concerning documentation and processing of services provided under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-9)*

460 IAC 6-10-10 Quality assurance and quality improvement system

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 10. (a) A provider shall have an internal quality assurance and quality improvement system that is:
(1) focused on the individual; and
(2) appropriate for the services being provided.

(b) The system described in subsection (a) shall include at least the following elements:
(1) An annual survey of individual satisfaction.
(2) Records of the findings of annual individual satisfaction surveys.
(3) Documentation of efforts to improve service delivery in response to the survey of individual satisfaction.
(4) An assessment of the appropriateness and effectiveness of each service provided to an individual.
(5) A process for:
(A) analyzing data concerning reportable incidents;
(B) developing recommendations to reduce the risk of future incidents; and
(C) reviewing recommendations to assess their effectiveness.
(6) If medication is administered to an individual by a provider, a process for:
(A) analyzing medication errors;
(B) developing recommendations to reduce the risk of future medication errors; and

(C) reviewing the recommendations to assess their effectiveness.

(7) If behavioral support services are provided by a provider, a process for:

(A) analyzing the appropriateness and effectiveness of behavioral support techniques used for an individual;

(B) developing recommendations concerning the behavioral support techniques used with an individual; and

(C) reviewing the recommendations to assess their effectiveness.

(8) If community habilitation and participation services or residential habilitation and support services are provided by the provider, a process for:

(A) analyzing the appropriateness and effectiveness of the instructional techniques used with an individual;

(B) developing recommendations concerning the instructional techniques used for an individual; and

(C) reviewing the recommendations to assess their effectiveness.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-10)

460 IAC 6-10-11 Prohibition against office in residence of individual

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 11. A provider shall not:

(1) maintain an office in an individual's residence; or

(2) conduct the provider's business operations not related to services to the individual in the individual's residence.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-11)

460 IAC 6-10-12 Human rights committee

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 12. A provider shall cooperate with the division's or the BDDS's regional human rights committee for the geographic area or areas in which the provider is providing services under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-12)*

460 IAC 6-10-13 Emergency behavioral support

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 13. (a) In an emergency, physical restraint or removal of an individual from the individual's environment may be used:

(1) without the necessity of a behavioral support plan; and

(2) only to prevent significant harm to the individual or others.

(b) The individual's support team shall meet not later than five (5) working days after an emergency physical restraint or removal of an individual from the environment in order to:

(1) review the circumstances of the emergency physical restraint or removal of an individual;

(2) determine the need for a:

(A) functional analysis;

(B) behavioral support plan; or

(C) both; and

(3) document recommendations.

(c) If a provider of behavioral support services is not a member an individual's support team, a provider of behavioral support services must be added to the individual's support team.

(d) Based on the recommendation of the support team, a provider of behavioral support services shall:

(1) complete a functional analysis within thirty (30) days; and

(2) make appropriate recommendations to the support team.

(e) The individual's support team shall:

(1) document the recommendations of the behavioral support services provider; and

(2) design an accountability system to insure implementation of the recommendations.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-10-13)

Rule 11. Financial Status of Providers

460 IAC 6-11-1 Applicability

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-11-1)*

460 IAC 6-11-2 Disclosure of financial information

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) A provider shall maintain and, upon the BDDS's request, shall make available to the BDDS the following information concerning the provider:

(1) Financial status.

(2) Current expenses and revenues.

(3) Projected budgets outlining future operations.

(4) Credit history and the ability to obtain credit.

(b) A provider shall maintain financial records in accordance with generally accepted accounting and bookkeeping practices.

(c) The financial status of a provider shall be audited

according to state board of accounts requirements and procedures. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-11-2)*

460 IAC 6-11-3 Financial stability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. A provider shall be financially stable, with the documented ability to deliver services without interruption for at least two (2) months without payment for services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-11-3)*

Rule 12. Insurance

460 IAC 6-12-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-12-1)*

460 IAC 6-12-2 Property and personal liability insurance
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. A provider shall secure insurance to cover:
(1) personal injury;
(2) loss of life; or
(3) property damage;
to an individual caused by fire, accident, or other casualty arising from, or occurring during, the provision of services to the individual by the provider. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-12-2)*

Rule 13. Transportation of an Individual

460 IAC 6-13-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-13-1)*

460 IAC 6-13-2 Transportation of an individual
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. A provider that transports an individual receiving services in a motor vehicle shall:
(1) maintain the vehicle in good repair;
(2) properly register with the Indiana bureau of motor vehicles; and
(3) insure the vehicle as required under Indiana law.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-13-2)

Rule 14. Professional Qualifications and Requirements

460 IAC 6-14-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-14-1)*

460 IAC 6-14-2 Requirement for qualified personnel
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. A provider shall ensure that services provided to an individual:
(1) meet the needs of the individual;
(2) conform to the individual's ISP; and
(3) are provided by qualified personnel as required under this article.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-14-2)

460 IAC 6-14-3 Documentation of qualifications
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. A provider shall maintain documentation that:
(1) the provider meets the requirements for providing services under this article; and
(2) the provider's employees or agents meet the requirements for providing services under this article.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-14-3)

460 IAC 6-14-4 Employee training
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) This section applies to a provider who uses employees or agents in the delivery of services.

(b) A provider shall train the provider's employees or agents in the protection of an individual's rights, including how to:
(1) respect the dignity of an individual;
(2) protect an individual from abuse, neglect, and exploitation;
(3) implement person-centered planning and an individual's ISP; and
(4) communicate successfully with an individual.

(c) A provider that develops training goals and objective for an individual shall train the provider's employees or agents in:
(1) selecting specific objectives;
(2) completing task analysis;
(3) appropriate locations for instruction; and

(4) appropriate documentation of an individual's progress on goals and objectives.

(d) A provider shall train direct care staff in providing a healthy and safe environment for an individual, including how to:

(1) administer medication, monitor side effects, and recognize and prevent dangerous medication interactions;
(2) administer first aid;
(3) administer cardiopulmonary resuscitation;
(4) practice infection control;
(5) practice universal precautions;
(6) manage individual-specific treatments and interventions, including management of an individual's:
(A) seizures;
(B) behavior;
(C) medication side effects;
(D) diet and nutrition;
(E) swallowing difficulties;
(F) emotional and physical crises; and
(G) significant health concerns; and
(7) conduct and participate in emergency drills and evacuations.

(e) Training shall be completed prior to the employee or agent working with an individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-14-4)*

460 IAC 6-14-5 Requirements for direct care staff
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 5. All direct care staff working with individuals shall meet the following requirements:

(1) Be at least eighteen (18) years of age.
(2) Demonstrate the ability to communicate adequately in order to:
(A) complete required forms and reports of visits; and
(B) follow oral or written instructions.
(3) Demonstrate the ability to provide services according to the individual's ISP.
(4) Demonstrate willingness to accept supervision.
(5) Demonstrate an interest in and empathy for individuals.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-14-5)

Rule 15. Personnel Records

460 IAC 6-15-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-15-1)*

460 IAC 6-15-2 Maintenance of personnel files
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) A provider shall maintain in the provider's office a file for each employee or agent of the provider.

(b) The provider's file for each employee or agent shall contain the following:

(1) A negative tuberculosis screening prior to providing services, and updated in accordance with recommendations of Centers for Disease Control.
(2) Cardiopulmonary resuscitation certification and recertification, updated annually.
(3) Auto insurance information, updated annually, if the employee or agent will be transporting an individual in the employee's or agent's personal vehicle.
(4) Limited criminal history information that meets the requirements of 460 IAC 6-10-5, with the information updated at least every three (3) years.
(5) Professional licensure, certification, or registration, including renewals, as applicable.
(6) A copy of the employee's or agent's driver's license, updated when the driver's license is due to expire.
(7) Copies of:
(A) the employee's time records; or
(B) the agent's invoices for services.
(8) Copies of the agenda for each training session attended by the employee or agent, including the following:
(A) Subject matter included in each training session.
(B) The date and time of each training session.
(C) The name of the person or persons conducting each training session.
(D) Documentation of the employee's or agent's attendance at each training session, signed by:
(i) the employee or agent; and
(ii) the trainer.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-15-2)

Rule 16. Personnel Policies and Manuals

460 IAC 6-16-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. (a) This rule applies to a provider who uses employees or agents to provide services.

(b) This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-16-1)*

460 IAC 6-16-2 Adoption of personnel policies
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) A provider shall:

(1) adopt and maintain a written personnel policy;
(2) review and update the personnel policy as appropriate; and

(3) distribute the personnel policy to each employee or agent.

(b) The written personnel policy required by subsection (a) shall include at least the following:

(1) A job description for each position, including the following:

(A) Minimum qualifications for the position.

(B) Major duties required of the position.

(C) Responsibilities of the employee in the position.

(D) The name and title of the supervisor to whom the employee in the position must report.

(2) A procedure for conducting reference, employment, and criminal background checks on each prospective employee or agent.

(3) A prohibition against employing or contracting with a person convicted of the offenses listed in 460 IAC 6-10-5.

(4) A process for evaluating the job performance of each employee or agent at the end of the training period and annually thereafter, including a process for feedback from individuals receiving services from the employee or agent.

(5) Disciplinary procedures.

(6) A description of grounds for disciplinary action against or dismissal of an employee or agent.

(7) A description of the rights and responsibilities of employees or agents, including the responsibilities of administrators and supervisors.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-16-2)

460 IAC 6-16-3 Policies and procedures documentation

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) A provider shall:

(1) adopt and maintain a written training procedure;

(2) review and update the training procedure as appropriate; and

(3) distribute the training procedure to the provider's employees or agents.

(b) The written training procedure required by subsection (a) shall include at least the following:

(1) Mandatory orientation for each new employee or agent to assure the employee's or agent's understanding of, and compliance with:

(A) the mission, goals, organization, and practices of the provider; and

(B) the applicable requirements of this article.

(2) A system for documenting the training for each employee or agent, including:

(A) the type of training provided;

(B) the name and qualifications of the trainer;

(C) the duration of training;

(D) the date or dates of training;

(E) the signature of the trainer, verifying the satisfactory completion of training by the employee or agent; and

(F) the signature of the employee or agent.

(3) A system for ensuring that a trainer has sufficient education, expertise, and knowledge of the subject to achieve listed outcomes required under the system.

(4) A system for providing annual in-service training to improve the competence of employees or agents in the following areas:

(A) Protection of individual rights, including protection against abuse, neglect, or exploitation.

(B) Incident reporting.

(C) Medication administration if the provider administers medication to an individual.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-16-3)

460 IAC 6-16-4 Operations manual

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) A provider shall compile the written policies and procedures required by sections 1 and 2 of this rule into a written operations manual.

(b) The operations manual shall be regularly updated and revised.

(c) Upon the request of the BDDS, the provider shall:

(1) supply a copy of the operations manual to the BDDS or other state agency, at no cost; and

(2) make the operations manual available to the BDDS or other state agency for inspection at the offices of the provider.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-16-4)

Rule 17. Maintenance of Records of Services Provided

460 IAC 6-17-1 Applicability

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. This rule applies to all supported living services and supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-17-1)*

460 IAC 6-17-2 Maintenance of records of services provided

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) This section applies to all providers.

(b) A provider shall maintain in the provider's office documentation of all services provided to an individual.

(c) Documentation related to an individual required by this article shall be maintained by the provider for at least seven (7) consecutive years.

(d) A provider shall analyze and update the documentation required by:

(1) the standards under this article applicable to the services the provider is providing to an individual;

(2) the professional standards applicable to the provider's profession; and

(3) the individual's ISP.

(e) A provider shall analyze and update the documentation at least every ninety (90) days if:

(1) the standards under this article do not provide a standard for analyzing and updating documentation;

(2) the professional standards applicable to the provider's profession do not provide a standard; or

(3) a standard is not set out in the individual's ISP.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-17-2)

460 IAC 6-17-3 Individual's personal file: site of service delivery

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) A provider specified in the individual's ISP as being responsible for maintaining the individual's personal file shall maintain a personal file for the individual at:

(1) the individual's residence; or

(2) the primary location where the individual receives services.

(b) The individual's personal file shall contain at least the following information:

(1) The individual's full name.

(2) Telephone numbers for emergency services that may be required by the individual.

(3) A current sheet with a brief summary regarding:

(A) the individual's diagnosis or diagnoses;

(B) the individual's treatment protocols, current medications, and other health information specified by the individual's ISP;

(C) behavioral information about the individual;

(D) likes and dislikes of the individual that have been identified in the individual's ISP; and

(E) other information relevant to working with the individual.

(4) The individual's history of allergies, if applicable.

(5) Consent by the individual or the individual's legal representative for emergency treatment for the individual.

(6) A photograph of the individual, if:

(A) a photograph is available; and

(B) inclusion of a photograph in the individual's file is specified by the individual's ISP.

(7) A copy of the individual's current ISP.

(8) A copy of the individual's behavioral support plan, if applicable.

(9) Documentation of:

(A) changes in the individual's physical condition or mental status during the last sixty (60) days;

(B) an unusual event such as vomiting, choking, falling, disorientation or confusion, behavioral problems, or seizures occurring during the last sixty (60) days; and

(C) the response of each provider to the observed change or unusual event.

(10) If an individual's goals include bill paying and other financial matters, the individual's file shall contain:

(A) the individual's checkbook with clear documentation that the checkbook has been balanced; and

(B) bank statements with clear documentation that the bank statements and the individual's checkbook have been reconciled.

(11) All environmental assessments conducted during the last sixty (60) days, with the signature of the person or persons conducting the assessment on the assessment.

(12) All medication administration documentation for the last sixty (60) days.

(13) All seizure management documentation for the last sixty (60) days.

(14) Health-related incident management documentation for the last sixty (60) days.

(15) All nutritional counseling services documentation for the last sixty (60) days.

(16) All behavioral support services documentation for the last sixty (60) days.

(17) All goal directed documentation for the last sixty (60) days.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-17-3)

460 IAC 6-17-4 Individual's personal file; provider's office

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) A provider specified in the individual's ISP as being responsible for maintaining the individual's personal file shall maintain a personal file for an individual at the provider's office.

(b) The individual's personal file shall contain documentation of the following:

(1) A change in an individual's physical condition or mental status.

(2) An unusual event for the individual.

(3) All health and medical services provided to an individual.

(4) An individual's training goals.

(c) A change or unusual event referred to in subsection (b) shall include the following:

(1) Vomiting.

(2) Choking.

(3) Falling.

(4) Disorientation or confusion.

(5) Patterns of behavior.

(6) A seizure.

(d) The documentation of a change or an event referred

to in subsections (b) and (c) shall include the following:

(1) The date, time, and duration of the change or event.

(2) A description of the response of the provider, or the provider's employees or agents to the change or event.

(3) The signature of the provider or the provider's employees or agents observing the change or event.

(e) The documentation of all health and medical services provided to the individual shall:

(1) be kept chronologically; and

(2) include the following:

(A) Date of services provided to the individual.

(B) A description of services provided.

(C) The signature of the health care professional providing the services.

(f) The individual's training file shall include documentation regarding the individual's training goals required by 460 IAC 6-24-1. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-17-4)*

Rule 18. Behavioral Support Services

460 IAC 6-18-1 Preparation of behavioral support plan

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. A behavioral support services provider shall prepare a behavioral support plan for an individual only after the provider has:

(1) directly observed the individual; and

(2) reviewed reports regarding the individual.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-18-1)

460 IAC 6-18-2 Behavioral support plan standards

Authority: IC 12-8-8-4; IC 12-9-2-2; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) A behavioral support plan shall meet the standards set out in this section.

(b) A behavioral support plan shall operationally define the targeted behavior or behaviors.

(c) A behavioral support plan shall be based upon a functional analysis of the targeted behaviors.

(d) A behavioral support plan shall contain written guidelines for teaching the individual functional and useful behaviors to replace the individual's maladaptive behavior.

(e) A behavioral support plan shall use nonaversive methods for teaching functional and useful replacement behaviors.

(f) A behavioral support plan shall conform to the individual's ISP, including the needs and outcomes identified in the ISP and the ISP's specifications for behavioral support services.

(g) A behavioral support plan shall contain documentation that each person implementing the plan:

(1) has received specific training as provided in the plan in the techniques and procedures required for implementing the behavioral support plan; and

(2) understands how to use the techniques and procedures required to implement the behavioral support plan;

regardless of whether the person implementing the plan is an employee or agent of the behavioral support services provider.

(h) A behavioral support plan shall contain a documentation system for direct care staff working with the individual to record episodes of the targeted behavior or behaviors. The documentation system shall include a method to record the following information:

(1) Dates and times of occurrence of the targeted behavior.

(2) Length of time the targeted behavior lasted.

(3) Description of what precipitated the targeted behavior.

(4) Description of what activities helped alleviate the targeted behavior.

(5) Signature of staff observing and recording the targeted behavior.

(i) If the use of medication is included in a behavioral support plan, a behavioral support plan shall contain:

(1) a plan for assessing the use of the medication and the appropriateness of a medication reduction plan; or

(2) documentation that a medication use reduction plan for the individual was:

(A) implemented within the past five (5) years; and

(B) proved to be not effective.

(j) If a highly restrictive procedure is included in a behavioral support plan, a behavioral support plan shall contain the following:

(1) A functional analysis of the targeted behavior for which a highly restrictive procedure is designed.

(2) Documentation that the risks of the targeted behavior have been weighed against the risk of the highly restrictive procedure.

(3) Documentation that systematic efforts to replace the targeted behavior with an adaptive skill were used and found to be not effective.

(4) Documentation that the individual, the individual's support team and the applicable human rights committee agree that the use of the highly restrictive method is required to prevent significant harm to the individual or others.

(5) Informed consent from the individual or the individual's legal representative.

(6) Documentation that the behavioral support plan is reviewed regularly by the individual's support team.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-18-2)

460 IAC 6-18-3 Written policy and procedure standards

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. A provider of behavioral support services shall have written policies and procedures that:

(1) limit the use of highly restrictive procedures, including physical restraint or medications to assist in the managing of behavior; and

(2) focus on behavioral supports that begin with less intrusive or restrictive methods before more intrusive or restrictive methods are used.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-18-3)

460 IAC 6-18-4 Documentation standards

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) A provider of behavioral support services shall maintain documentation regarding the development of a behavioral support plan that:

(1) the least intrusive method was attempted and exhausted first; and

(2) if a highly restrictive procedure is deemed to be necessary and included in a behavioral support plan, the actions required by section 2(j) of this rule have been taken.

(b) A provider of behavioral support services shall maintain the following documentation for each individual served:

(1) A copy of the individual's behavioral support assessment.

(2) If applicable, the individual's behavioral support plan.

(3) Dates, times, and duration of each visit with the individual.

(4) A description of the behavioral support activities conducted.

(5) A description of behavioral support progress made.

(6) The signature of the person providing the behavioral support services on each date the behavioral support service is provided.

(7) If applicable, a copy of each individual's behavioral support plan.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-18-4)

460 IAC 6-18-5 Level 2 clinician standards

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 5. (a) If a behavioral support plan is developed by a Level 2 clinician, the Level 2 clinician shall be supervised by a Level 1 clinician.

(b) A Level 1 clinician shall give written approval of all behavioral support plans developed by a Level 2 clinician.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-18-5)

460 IAC 6-18-6 Implementation of behavioral support plan

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 6. All providers working with an individual shall implement the behavioral support plan designed by the individual's behavioral support services provider. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-18-6)*

460 IAC 6-18-7 Human rights committee

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 7. A provider of behavioral support services who:

(1) prepares a behavioral support plan; or

(2) implements a behavioral support plan;

shall cooperate with the division's or the BDDS's regional human rights committee for the geographic area in which the provider is providing services under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-18-7)*

Rule 19. Case Management

460 IAC 6-19-1 Information concerning an individual

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. A provider of case management services shall have the following information about an individual receiving case management services from the provider:

(1) The wants and needs of an individual, including the health, safety and behavioral needs of an individual.

(2) The array of services available to an individual whether the services are available under this article or are otherwise available.

(3) The availability of funding for an individual.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-1)

460 IAC 6-19-2 Training and orientation

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) To maintain the BDDS's approval to provide case management services under this article, a provider shall complete twenty (20) hours of training regarding case management services in each calendar year.

(b) The training prescribed by subsection (a) shall include at least ten (10) hours of training approved by the BDDS.

(c) If the BDDS identifies a systemic problem with a provider's case management services, the provider of case management services shall obtain training on the topics recommended by the BDDS. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-2)*

460 IAC 6-19-3 Contact information
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) A provider of case management services shall give the individual or the individual's legal representative, if applicable, clear instructions for contacting the provider.

(b) A provider of case management services shall give the individual or the individual's legal representative, if applicable, a summary of information and procedures if the individual needs assistance or has an emergency before or after business hours. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-3)*

460 IAC 6-19-4 Distribution of information
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. A provider of case management services shall ensure that:
(1) the individual;
(2) the individual's legal representative, if applicable; and
(3) all other providers of services to the individual, regardless of whether the services are provided pursuant to this article;
have copies of relevant documentation, including information on individual rights, an individual's approved plan of care, filing complaints, and requesting appeals concerning issues and disputes relating to the services provided to the individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-4)*

460 IAC 6-19-5 Evaluation of available providers
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 5. (a) A provider of case management services shall provide the individual or the individual's legal representative, if applicable, with the following information:
(1) A current list of providers approved under this article, including a complete description of services offered by each provider.
(2) Information regarding services the individual may need that are not provided under this article.
(3) The current BDDS information guide for individuals on how to choose a provider.

(b) The provider of case management services shall assist the individual or the individual's legal representative, if applicable, in evaluating potential service providers. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-5)*

460 IAC 6-19-6 Monitoring of services
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 6. (a) A provider of case management shall monitor and document the quality, timeliness, and appropriateness of the care, services, and products delivered to an individual.

(b) The documentation required under this section shall include an assessment of the following:
(1) The appropriateness of the goals in the individual's ISP.
(2) An individual's progress toward the goals in the individual's ISP.

(c) The documentation required by this section shall include the following:
(1) Any medication administration system for the individual.
(2) An individual's behavioral support plan.
(3) Any health-related incident management system for the individual.
(4) Any side effect monitoring system for the individual.
(5) Any seizure management system for the individual.
(6) Any other system for the individual implemented by more than one (1) provider.

(d) A provider of case management services shall continuously monitor the services and outcomes established for the individual in the individual's ISP, including the following:
(1) A provider of case management services shall timely follow-up on identified problems.
(2) A provider of case management services shall act immediately to resolve critical issues and crises in accordance with this article.
(3) If concerns with services or outcomes are identified, a provider of case management services shall:
(A) address the concerns in a timely manner; and
(B) involve all necessary providers and the individual's support team if necessary.

(e) A provider of case management services who is attempting to resolve a dispute shall follow the dispute resolution procedure described in 460 IAC 6-10-8.

(f) No later than thirty (30) days after the implementation of an individual's ISP, unless otherwise specified in the ISP, a provider of case management shall make the first monitoring contact with the individual.

(g) A provider of case management services shall have regular in-person contact with the individual as required by the ISP and this section. The provider of case management services shall make at least:

(1) one (1) in-person contact with the individual every ninety (90) days to assess the quality and effectiveness of the ISP;
(2) two (2) in-person contacts each year in the individual's residence; and
(3) one (1) in-person contact each year unannounced.

(h) If an individual's ISP requires more contact than required by subsection (g), the individual's ISP shall control the amount of contact a provider of case management services must make with an individual receiving case management services.

(i) A provider of case management services shall coordinate the provision of family and caregiver training services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-6)*

460 IAC 6-19-7 Documentation of services provided
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 7. (a) A provider of case management services shall maintain documentation of each contact with an:
(1) individual; and
(2) individual's providers.

(b) The documentation shall be updated and revised whenever case management services are provided for the individual.

(c) If a provider of case management services visits an individual at the individual's residence, the provider must sign in with the provider of environmental and living arrangement supports. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-7)*

460 IAC 6-19-8 Documentation; problem resolution
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 8. (a) A provider of case management services shall document the following:
(1) The provider's follow-up on problems.
(2) The resolution of problems.

(b) A provider of case management services shall keep the documentation required in this section in an individual's personal record maintained by the case manager. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-8)*

460 IAC 6-19-9 Conflict of interest
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 9. If a person provides case management services to an individual, then that person shall not provide any other service under this article to that particular individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-19-9)*

Rule 20. Community-Based Sheltered Employment Services

460 IAC 6-20-1 Staffing requirements
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. Community-based sheltered employment services shall be provided with a staff ratio that does not exceed eight (8) individuals to one (1) staff member. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-20-1)*

460 IAC 6-20-2 Integrated setting required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. Community-based employment services shall be provided in an integrated setting. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-20-2)*

Rule 21. Environmental Modification Supports

460 IAC 6-21-1 Warranty required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. All environmental modification supports provided to an individual under this rule shall be warranted for at least ninety (90) days. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-21-1)*

460 IAC 6-21-2 Documentation required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. A provider of environmental modification supports shall maintain the following documentation regarding support provided to an individual:
(1) The installation date of any adaptive aid or device, assistive technology, or other equipment.
(2) The maintenance date of any adaptive aid or device, assistive technology, or other equipment.
(3) A change made to any adaptive aid or device, assistive technology, or other equipment, including any:
(A) alteration;
(B) correction; or
(C) replacement.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-21-2)

Rule 22. Facility-Based Sheltered Employment Services

460 IAC 6-22-1 Staffing requirement
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. All facility-based sheltered employment services

shall be provided with a staff ratio that does not exceed twenty (20) individuals to one (1) staff member. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-22-1)*

Rule 23. Family and Caregiver Training Services

460 IAC 6-23-1 Requirements for provision of services
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. A person providing family and caregiver training services shall have:
(1) education;
(2) training; or
(3) experience;
directly related to the training the person will be providing. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-23-1)*

460 IAC 6-23-2 Supervision of providers
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. Any person providing family and caregiver training services shall be supervised by the:
(1) individual whose family members or caregiver is receiving training; and
(2) provider of case management services to the individual.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-23-2)

Rule 24. Training Services

460 IAC 6-24-1 Coordination of training services and training plan
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. (a) A provider designated in an individual's ISP as responsible for providing training to an individual shall create a training plan for the individual.

(b) A training plan shall:
(1) consist of a formal description of goals, objectives, and strategies, including:
(A) desired outcomes; and
(B) persons responsible for implementation; and
(2) be designed to enhance skill acquisition and increase independence.

(c) The provider shall assess the appropriateness of an individual's goals at least once every ninety (90) days.

(d) All providers responsible for providing training to an individual shall:
(1) coordinate the training services provided to an individual; and
(2) share documentation regarding the individual's training;
as required by the individual's ISP. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-24-1)*

460 IAC 6-24-2 Required documentation
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) The provider identified in section 1 of this rule shall maintain a personal file for each individual served.

(b) The individual's file shall:
(1) be kept chronologically; and
(2) include the following information:
(A) Measurement of the individual's progress toward each training goal identified in the individual's ISP.
(B) Dates, times, and duration of training services provided to the individual.
(C) A description of training activities conducted on each date.
(D) The signature of the person providing the service each time training is provided.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-24-2)

460 IAC 6-24-3 Management of individual's financial resources
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) This section applies to:
(1) an individual's residential living allowance management services provider; or
(2) the provider identified in an individual's individualized support plan as being responsible for an individual's property or financial resources.

(b) The provider shall assist an individual to:
(1) obtain, possess, and maintain financial assets, property, and economic resources; and
(2) obtain insurance at the individual's expense to protect the individual's assets and property.

(c) If the provider is responsible for management of an individual's funds, the provider shall do the following:
(1) Maintain separate accounts for each individual.
(2) Provide monthly account balances and records of transactions to the individual and, if applicable, the individual's legal representative.
(3) Inform the individual or the individual's legal representative, if applicable, that the payee is required by law to spend the individual's funds only for the needs of the individual.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-24-3)

Rule 25. Health Care Coordination Services

460 IAC 6-25-1 Provider of health care coordination services
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. Coordination of the health care for an individual shall be the responsibility of either of the following:

(1) A provider of health care coordination services.

(2) The provider identified in an individual's ISP as responsible for the health care of the individual.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-1)

460 IAC 6-25-2 Coordination of health care
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. The provider identified in section 1 of this rule shall coordinate the health care received by the individual, including:

(1) annual physical, dental, and vision examinations;

(2) routine examinations;

(3) routine screenings; and

(4) identification and treatment of allergies;

as ordered by the individual's physician. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-2)*

460 IAC 6-25-3 Documentation of health care services received by an individual
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) The provider identified in section 1 of this rule shall maintain a personal file for each individual served.

(b) The individual's personal file shall contain the following information:

(1) The date of health and medical services provided to the individual.

(2) A description of the health care or medical services provided to the individual.

(3) The signature of the person providing the health care or medical service for each date a service is provided.

(4) Additional information and documentation required in this rule, including documentation of the following:

(A) An organized system for medication administration.

(B) An individual's refusal to take medication.

(C) Monitoring of medication side effects.

(D) Seizure tracking.

(E) Changes in an individual's status.

(F) An organized system of health-related incident management.

(G) If applicable to this provider, an investigation of the death of an individual.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-3)

460 IAC 6-25-4 Organized system for medication administration required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) The provider identified in section 1 of this rule shall design an organized system of medication administration for the individual.

(b) The provider shall:

(1) document the system in writing; and

(2) distribute the document to all providers administering medication to the individual.

(c) The document shall be placed in the individual's file maintained by all providers administering medication to the individual.

(d) The system required in subsection (a) shall contain at least the following elements:

(1) Identification and description of each medication required for the individual.

(2) Documentation that the individual's medication is administered only by trained and authorized personnel unless the individual is capable of self-administration of medication as provided for in the individual's ISP.

(3) Documentation of the administration of medication, including the following:

(A) Administration of medication from original labeled prescription containers.

(B) Name of medication administered.

(C) Amount of medication administered.

(D) The date and time of administration.

(E) The initials of the person administering the medication.

(4) Procedures for the destruction of unused medication.

(5) Documentation of medication administration errors.

(6) A system for the prevention or minimization of medication administration errors.

(7) When indicated as necessary by an individual's ISP, procedures for the storage of medication:

(A) in the original labeled prescription container;

(B) in a locked area when stored at room temperature;

(C) in a locked container in the refrigerator if refrigeration is required;

(D) separately from nonmedical items; and

(E) under prescribed conditions of temperature, light, humidity, and ventilation.

(8) Documentation of an individual's refusal to take medication as required in section 5 of this rule.

(9) A system for communication among all providers that administer medication to an individual.

(10) All providers administering medication to the individual shall:

(A) implement; and

(B) comply with;

the organized system of medication administration

designed by the provider designated in section 1 of this rule.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-4)

460 IAC 6-25-5 Individual's refusal to take medication

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 5. (a) If an individual refuses to take medication, the provider attempting to administer the medication shall do the following:

(1) Document the following information:

(A) The name of the medication refused by the individual.

(B) The date, time, and duration of the refusal.

(C) A description of the provider's response to the refusal.

(D) The signature of the person or persons observing the refusal.

(2) Supply the documentation to the provider identified in section 1 of this rule.

(b) The provider identified in section 1 of this rule shall review the individual's refusal to take medication with:

(1) the individual's physician; and

(2) the individual's support team;

to ensure the health and safety of the individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-5)*

460 IAC 6-25-6 Monitoring of medication side effects

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 6. (a) The provider designated in section 1 of this rule shall design a system to monitor side effects an individual may experience as a result of medication the individual takes.

(b) The provider shall:

(1) document the system in writing; and

(2) distribute the document to all providers working with the individual.

(c) The system required in subsection (a) shall contain at least the following elements:

(1) Training of direct care staff, employees, and agents concerning:

(A) the identification of:

(i) side effects; and

(ii) interactions;

of all medication administered to an individual; and

(B) instruction on medication side effects and interactions.

(2) A side effect tracking record that includes:

(A) how often the individual should be monitored for side effects of each medication administered to the individual;

(B) who shall perform the monitoring; and

(C) when monitoring shall be performed.

(3) A system for communication among all providers working with an individual regarding the monitoring of medication side effects.

(d) All providers working with an individual shall:

(1) implement; and

(2) comply with;

the medication side effect monitoring system designed by the provider designated in section 1 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-6)*

460 IAC 6-25-7 Seizure management

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 7. (a) The provider designated in section 1 of this rule shall design a system of seizure management for the individual.

(b) The provider shall communicate the system in writing to all providers working with the individual.

(c) The system of seizure management prescribed by subsection (a) shall include at least the following elements:

(1) Training of direct care staff, employees, or agents concerning the administration of medication.

(2) A seizure tracking record for documenting events:

(A) immediately preceding a seizure;

(B) during a seizure; and

(C) following a seizure.

(3) Documentation of any necessary physician follow-up and follow along services.

(4) A system for checking the individual's levels of seizure medication:

(A) at least annually; or

(B) as ordered by the individual's physician.

(5) A system for communication among all providers working with the individual concerning the individual's seizures.

(d) All providers working with the individual shall:

(1) implement; and

(2) comply with;

the seizure management system developed by the provider designated in section 1 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-7)*

460 IAC 6-25-8 Changes in an individual's status

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 8. (a) The provider identified in section 1 of this rule shall maintain a personal file for an individual at the provider's office. The file shall contain documentation of any change in an individual's physical condition, mental status, or any unusual event, including the following:

(1) Vomiting.
(2) Choking.
(3) Falling.
(4) Disorientation or confusion.
(5) Patterns of behavior.
(6) Seizures.

(b) The documentation of a change or event required by subsection (a) shall include:
(1) dates, times, and duration of the change or event;
(2) a description of the response of the provider, or the provider's employees or agents to the change or event; and
(3) the signature of the person or persons observing the change or event.

(c) A provider or providers working with an individual shall supply to the provider identified in section 1 of this rule any information regarding any change or event listed in subsection (a) that is observed while the provider is providing services to the individual.

(d) Except as provided in subsection (e), a provider observing a change in an individual's physical condition or mental status, or any unusual event, shall supply the information required in subsection (c) to the provider identified in section 1 of this rule as follows:
(1) within twenty-four (24) hours of the change or event; or
(2) by noon on the next business day;
whichever is later.

(e) If the change in an individual's physical condition or mental status or the unusual event is also a reportable incident under 460 IAC 6-9-5, the information shall be provided within twenty-four (24) hours. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-8)*

460 IAC 6-25-9 Health-related incident management
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 9. (a) The provider identified in section 1 of this rule shall design a system of management for health-related incidents involving an individual.

(b) The health-related incident management system prescribed by subsection (a) shall provide an internal review process for any health-related reportable incident. The provider's internal review process shall include at least the following:
(1) A trend analysis of incidents for an individual.
(2) Documentation:
(A) that summarizes the findings of the analysis conducted under subdivision (1); and
(B) of the steps taken to prevent or minimize the occurrence of incidents in the future.
(3) A system for communication among all providers working with an individual regarding health-related incidents involving the individual.

(c) All providers working with an individual shall implement the health-related incident management system designed by the provider identified in section 1 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-9)*

460 IAC 6-25-10 Investigation of death
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 10. (a) If an individual dies, an investigation into the death shall be conducted by the provider identified in section 1 of this rule, except as provided in subsection (b).

(b) If the provider identified in section 1 of this rule is a family member of the individual, then the provider of case management services to an individual shall conduct an investigation into the death of the individual.

(c) A provider conducting an investigation into the death of an individual shall meet the following requirements:
(1) Notify by telephone the BDDS's central office in Indianapolis not later than twenty-four (24) hours after the death.
(2) Notify adult protective services or child protection services, as applicable, not later than twenty-four (24) hours after the death.
(3) Collect and review documentation of all events, incidents, and occurrences in the individual's life for at least the thirty (30) day period immediately before:
(A) the death of the individual;
(B) the hospitalization in which the individual's death occurred; or
(C) the individual's transfer to a nursing home in which death occurred within ninety (90) days of that transfer.
(4) In conjunction with all providers of services to the deceased individual, review and document all the actions of all employees or agents of all providers for the thirty (30) day period immediately before:
(A) the individual's death;
(B) the hospitalization in which the individual's death occurred; or
(C) the individual's transfer to a nursing home in which death occurred within ninety (90) days of that transfer.
(5) Document conclusions and make recommendations arising from the investigation.
(6) Document implementation of any recommendations made under subdivision (5).
(7) No later than fifteen (15) days after the individual's death, send to the BDDS:
(A) a completed notice of an individual's death on a form prescribed by the BDDS; and
(B) a final report that includes all documentation

required by subdivisions (1) through (6) for review by the division's mortality review committee.

(d) A provider shall respond to any additional requests for information made by the mortality review committee within seven (7) days of the provider's receipt of a request.

(e) A provider shall submit the documentation to the BDDS to support the provider's implementation of specific recommendations made by the mortality review committee. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-25-10)*

Rule. 26. Nutritional Counseling Services

460 IAC 6-26-1 Specialized diet program
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. (a) A provider of nutritional counseling services shall design and document a dining plan for an individual in accordance with the individual's ISP.

(b) An individual's dining plan shall include the following:
(1) Any special dining needs of an individual.
(2) Identification of swallowing difficulties.
(3) Identification of risk of aspiration.
(4) The need for adaptive equipment.

(c) A provider who has designed a dining plan for an individual shall provide assessment and oversight of:
(1) the dining plan; and
(2) the person or persons implementing the dining plan.

(d) A provider shall follow any specialized diet program designed by the provider of nutritional counseling services to an individual, including any documentation requirements contained in the individual's dining plan. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-26-1)*

Rule 27. Occupational Therapy Services

460 IAC 6-27-1 Supervision
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. Any occupational therapy assistant or occupational therapy aide assisting in the delivery of occupational therapy services to an individual shall do so under the direct supervision of an occupational therapist approved under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-27-1)*

Rule 28. Personal Emergency Response System Supports

460 IAC 6-28-1 Warranty required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. All personal emergency response system supports provided to an individual under this rule shall be warranted for at least ninety (90) days. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-28-1)*

460 IAC 6-28-2 Documentation
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. A provider of personal emergency response system supports shall maintain the following documentation regarding support provided to an individual:
(1) The installation date of any device.
(2) The maintenance date of any device.
(3) Any change made to any device, including an alteration, correction or replacement.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-28-2)

Rule 29. Physical Environment

460 IAC 6-29-1 Environment shall conform to ISP
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. A provider designated in the individual's ISP as responsible for providing environmental and living arrangement support for the individual shall ensure that an individual's physical environment conforms to the requirements of:
(1) the individual's ISP; and
(2) this rule.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-29-1)

460 IAC 6-29-2 Safety of individual's environment
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. (a) A provider designated in the individual's ISP as responsible for providing environmental and living arrangement support shall provide services in a safe environment that is:
(1) maintained in good repair, inside and out; and
(2) free from:
(A) combustible debris;
(B) accumulated waste material;
(C) offensive odors; and
(D) rodent or insect infestation.

(b) The provider shall ensure that:
(1) an assessment of the individual's environment is conducted every ninety (90) days; and
(2) the results of the assessment are documented.

(c) If an environmental assessment determines that an environment is unsafe for an individual, the provider shall

take the appropriate steps to ensure that the individual is safe, including the following, when appropriate:

(1) Filing an incident report.

(2) Working with the individual and the support team to resolve physical environmental issues.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-29-2)

460 IAC 6-29-3 Monitoring an individual's environment

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. The provider designated in an individual's ISP as responsible for providing environmental and living arrangement support shall ensure that appropriate devices or home modifications, or both:

(1) are provided to the individual in accordance with the individual's ISP; and

(2) satisfy the federal Americans with Disabilities Act requirements and guidelines.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-29-3)

460 IAC 6-29-4 Compliance of environment with building and fire codes

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 4. (a) A provider designated in an individual's ISP as responsible for providing environmental and living arrangement support shall ensure that an individual's living areas comply with the requirements of this section.

(b) An individual's living areas shall meet Indiana Code and local building requirements for single family dwellings or multiple family dwellings as applicable.

(c) An individual's living areas shall contain a working smoke detector or smoke detectors that are:

(1) tested at least once a month; and

(2) located in areas considered appropriate by the local fire marshal.

(d) An individual's living areas shall contain a working fire extinguisher or extinguishers that are inspected annually.

(e) An individual's living areas shall:

(1) contain operable antiscald devices; or

(2) have hot water temperature no higher than one hundred ten (110) degrees Fahrenheit;

if required by an individual's ISP. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-29-4)*

460 IAC 6-29-5 Safety and security policies and procedures

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 5. (a) A provider designated in an individual's ISP as responsible for providing environmental and living arrangement support for the individual shall:

(1) maintain specific written safety and security policies and procedures for an individual; and

(2) train all employees or agents in implementing the policies and procedures.

(b) The policies and procedures prescribed by subsection (a) shall include at least the following:

(1) When and how to notify law enforcement agencies in an emergency or crisis.

(2) Scheduling and completion of evacuation drills.

(3) Adopting procedures that shall be followed in an emergency or crisis, such as a tornado, fire, behavioral incident, elopement, or snow.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-29-5)

460 IAC 6-29-6 Safety and security training

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 6. (a) A provider designated in an individual's ISP as responsible for providing environmental and living arrangement support shall provide training to:

(1) the provider's employees or agents; and

(2) the individual, in the individual's mode of communication;

concerning procedures to be followed in an emergency or crisis.

(b) The training prescribed by subsection (a) shall include the following:

(1) Evacuation procedures.

(2) Responsibilities during drills.

(3) The designated meeting place outside the site of service delivery in an emergency.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-29-6)

460 IAC 6-29-7 Individual's inability to follow safety and security procedures

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 7. If an individual is medically or functionally unable to follow procedures for dealing with an emergency or crisis, the provider of environmental and living arrangement support shall document in writing:

(1) that the individual is unable to follow emergency or crisis procedures; and

(2) the provider's plan for support of the individual in an emergency or crisis.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-29-7)

460 IAC 6-29-8 Emergency telephone numbers
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 8. (a) A provider designated in an individual's ISP as responsible for providing environmental and living arrangement support shall ensure that an emergency telephone number list is located:
(1) in an area visible from the telephone used by an individual; or
(2) as indicated in the individual's ISP.

(b) The emergency telephone list shall include the following:
(1) Information given to the individual by the individual's provider of case management services.
(2) The local emergency number, for example, 911.
(3) The telephone number of the individual's legal representative or advocate, if applicable
(4) Any telephone numbers specified in the individual's ISP, including telephone numbers for the following:
(A) The local BDDS office.
(B) The provider of case management services to the individual.
(C) Adult protective services or child protection services as applicable.
(D) The developmental disabilities waiver ombudsman.
(E) Any other service provider identified in the individual's ISP.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-29-8)

Rule 30. Psychological Therapy Services

460 IAC 6-30-1 Supervision
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. To provide psychological therapy services under this article, the following persons shall be supervised by a licensed psychologist:
(1) A marriage and family therapist.
(2) A mental health counselor.
(3) A clinical social worker.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-30-1)

Rule 31. Residential Living Allowance and Management Services

460 IAC 6-31-1 Documentation required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. A provider of residential living allowance and management services shall maintain the following documentation:
(1) Documentation that an individual's residential living allowance was deposited in the individual's personal account.
(2) Receipts for all expenditures made from the individual's financial resources and food stamps, including receipts for rent, utilities, groceries, clothing, household goods, and other expenditures.
(3) If applicable, an individual's ICLB.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-31-1)

Rule 32. Respite Care Services

460 IAC 6-32-1 Documentation required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. (a) A provider of respite care services shall maintain chronological documentation of the services provided for an individual.

(b) The documentation shall include the following:
(1) The date and duration of respite care services provided.
(2) The signature of the person providing respite care services.
(3) The location and setting where the respite care service was provided.

(c) Documentation shall be updated, reviewed and analyzed whenever respite care services are provided. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-32-1)*

Rule 33. Specialized Medical Equipment and Supplies Supports

460 IAC 6-33-1 Warranty required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. All specialized medical equipment and supplies supports provided to an individual under this rule shall be warranted for at least ninety (90) days. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-33-1)*

460 IAC 6-33-2 Documentation required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. A provider of specialized medical equipment and supplies supports shall maintain the following documentation regarding support provided to an individual:
(1) The installation date of any adaptive aid or device, assistive technology, or other equipment.
(2) The maintenance date of any adaptive aid or device, assistive technology, or other equipment.
(3) Any change made to any adaptive aid or device, assistive technology, or other equipment, including an alteration, correction, or replacement.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-33-2)

Rule 34. Speech-Language Therapy Services

460 IAC 6-34-1 Supervision required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. Any speech-language pathology aide providing speech-language services under this article shall provide services under the direct supervision of a speech pathologist approved under this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-34-1)*

Rule 35. Transportation Services

460 IAC 6-35-1 Valid driver's license required
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 1. A provider of transportation services shall ensure that an individual is transported only by a person who has a valid Indiana:
(1) operator's license;
(2) chauffeur's license;
(3) public passenger chauffeur's license; or
(4) commercial driver's license;
issued to the person by the Indiana bureau of motor vehicles to drive the type of motor vehicle for which the license was issued. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-35-1)*

460 IAC 6-35-2 Vehicle requirements
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 2. A provider of transportation services shall ensure that an individual is transported only in a vehicle:
(1) maintained in good repair;
(2) properly registered with the Indiana bureau of motor vehicles; and
(3) insured as required under Indiana law.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-35-2)

460 IAC 6-35-3 Vehicle liability insurance
Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-11-1.1-9; IC 12-11-2.1-12
Affected: IC 12-11-1.1; IC 12-11-2.1

Sec. 3. (a) A provider of transportation services shall secure liability insurance for all vehicles:
(1) owned or leased by the provider; and
(2) used for the transportation of an individual receiving services.

(b) The liability insurance required by subsection (a) shall cover:
(1) personal injury;
(2) loss of life; or
(3) property damage;
to an individual, if the loss, injury, or damage occurs during the provision of transportation services to the individual by the provider. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 6-35-3)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on August 22, 2002 at 2:00 p.m., at the Indianapolis-Marion County Public Library, 1801 Nowland Avenue, Indianapolis, Indiana; ***AND*** *on August 22, 2002 at 5:00 p.m., at the Indianapolis-Marion County Public Library, 1801 Nowland Avenue, Indianapolis, Indiana;* ***AND*** *on August 22, 2002 at 2:00 p.m., at the New Albany-Floyd County Public Library, 180 West Spring Street, New Albany, Indiana;* ***AND*** *on August 22, 2002 at 5:00 p.m., at the New Albany-Floyd County Public Library, 180 West Spring Street, New Albany, Indiana;* ***AND*** *on August 22, 2002 at 2:00 p.m., at the Valparaiso Public Library, 103 Jefferson Street, Valparaiso, Indiana;* ***AND*** *on August 22, 2002 at 5:00 p.m., at the Valparaiso Public Library, 103 Jefferson Street, Valparaiso, Indiana the Division of Disability, Aging, and Rehabilitative Services will hold a public hearing on proposed new rules concerning supported living services and supports for individuals with a developmental disability. The proposed new rules include qualifications for approved providers of supported living services and supports; the process by which providers are approved; the process for monitoring and ensuring compliance with provider standards and requirements; the rights of individuals receiving services; protection of individuals receiving services; and standards and requirements for approved providers of supported living services and supports. If an accommodation is required to allow an individual with a disability to participate in a public hearing, please contact Barbara Nardi at (317) 232-1246 at least 48 hours before the hearing. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.*

Steven C. Cook
Director
Division of Disability, Aging, and Rehabilitative Services

TITLE 852 INDIANA OPTOMETRY BOARD

Proposed Rule
LSA Document #02-131

DIGEST

Amends 852 IAC 1-1.1-4 concerning application for a license to practice optometry; approval of schools of optometry. Effective 30 days after filing with the secretary of state.

852 IAC 1-1.1-4

SECTION 1. 852 IAC 1-1.1-4 IS AMENDED TO READ AS FOLLOWS:

852 IAC 1-1.1-4 Applicant fees, transcripts, examination scores, and photographs

Authority: IC 25-24-1-1
Affected: IC 25-24-1-3

Sec. 4. (a) Each applicant shall submit the following information:

(1) The examination fee required by 852 IAC 1-10-1.

(2) Official transcripts, certified by the school, recording courses, grades, certificates, and degrees earned in an accredited optometry school.

(3) The official score report from the National Board of Examiners in Optometry with passing scores in all parts, including the treatment and management of ocular disease examination.

(4) One (1) passport-quality photograph taken not earlier than one (1) year prior to the date of application, dated and signed on the back in the applicant's handwriting, "I certify that this is a true photograph of me.".

(b) The Indiana optometry board adopts the procedures and standards of the **Accreditation** Council on Optometric Education for approval of schools of optometry and will only accept graduates of optometry schools accredited by the council as applicants for licensure, provided all other requirements are met.

(c) The document entitled "Accreditation Manual: Professional Optometric Degree Programs", ~~published~~ **adopted** by the **Accreditation** Council on Optometric Education **(then known as the Council on Optometric Education** of the American Optometric Association ~~Ninth Edition, published in June 1983,~~ **or COE), effective on July 1, 1994, and updated effective January 1, 2000,** is hereby incorporated by reference and made applicable to this title and specifically to this ~~section.~~ **chapter.** A copy of the document may be purchased by contacting the **Accreditation** Council on Optometric Education, American Optometric Association, 243 North Lindbergh Boulevard, St. Louis, Missouri 63141 or the bureau. **The document is also available on the Internet at www.theaoa.org/accreditation.html.** *(Indiana Optometry Board; 852 IAC 1-1.1-4; filed Jul 29, 1980, 9:35 a.m.: 3 IR 1507; filed Sep 1, 1981, 9:15 a.m.: 4 IR 2026; filed Feb 4, 1986, 2:22 p.m.: 9 IR 1373; errata, 9 IR 2064; filed Feb 13, 1992, 10:00 a.m.: 15 IR 1220; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2333; readopted filed Jul 10, 2001, 3:00 p.m.: 24 IR 4238)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on November 13, 2002 at 9:15 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 10, Indianapolis, Indiana the Indiana Optometry Board will hold a public hearing on proposed rules concerning the application for a license to practice optometry and approval of schools of optometry. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W041 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Lisa R. Hayes
Executive Director
Health Professions Bureau

TITLE 852 INDIANA OPTOMETRY BOARD

Proposed Rule
LSA Document #02-132

DIGEST

Amends 852 IAC 1-13-1 concerning license revocation and the duties of practitioners whose licenses have been revoked. Amends 852 IAC 1-13-2 concerning license suspension and the duties of practitioners whose licenses have been suspended. Effective 30 days after filing with the secretary of state.

852 IAC 1-13-1
852 IAC 1-13-2

SECTION 1. 852 IAC 1-13-1 IS AMENDED TO READ AS FOLLOWS:

852 IAC 1-13-1 License revocation; duties of licensees

Authority: IC 25-24-1-1
Affected: IC 25-24-1-3

Sec. 1. In any case where a practitioner's license has been revoked, said person shall **do the following:**

(1) Promptly notify, or cause to be notified in the manner and method specified by the board, all patients then in the care of the practitioner, or those persons responsible for the patient's care, of the revocation and of the practitioner's consequent inability to act for or on their behalf in the practitioner's professional capacity. Such notice shall advise all patients to seek the services of another practitioner in good standing of their own choice.

(2) Promptly notify, or cause to be notified, all health care facilities where such practitioner has privileges, of the revocation accompanied by a list of all patients then in the care of such practitioner.

(3) Notify in writing, by first class mail, the following organizations and governmental agencies of the revocation of licensure:

(A) Indiana ~~department of public welfare~~ **family and social services administration.**

(B) Social Security Administration.

(C) The boards or equivalent agency of each state in which the person is licensed to practice optometry.

(D) The ~~International~~ Association of **Regulatory** Boards of ~~Examiners in~~ Optometry. ~~Inc.~~

(4) Make reasonable arrangements with said ~~licensee's~~ **practitioner's** active patients for the transfer of all patient records, studies and test results, or copies thereof, to a succeeding practitioner employed by the patient or by those responsible for the patient's care.

(5) Within thirty (30) days after the date of license revocation, the practitioner shall file an affidavit with the board showing compliance with the provisions of the revocation order and with ~~852 IAC 1-13,~~ **this rule,** which time may be extended by the board. Such affidavit shall also state all other jurisdictions in which the practitioner is still licensed.

(6) Proof of compliance with this section shall be a condition precedent to **filing** any ~~petition for reinstatement.~~ **application for licensure.**

(Indiana Optometry Board; 852 IAC 1-13-1; filed May 11, 1987, 9:00 a.m.: 10 IR 1878; readopted filed Jul 10, 2001, 3:00 p.m.: 24 IR 4238)

SECTION 2. 852 IAC 1-13-2 IS AMENDED TO READ AS FOLLOWS:

852 IAC 1-13-2 License suspension; duties of licensees

Authority: IC 25-24-1-1
Affected: IC 25-24-1-3

Sec. 2. (a) In any case where a person's license has been suspended, said person shall, within thirty (30) days from the date of the order of suspension, file with the board an affidavit that **confirms the following:**

(1) All active patients then under the practitioner's care have been notified in the manner and method specified by the board of the practitioner's suspension and consequent inability to act for or on their behalf in a professional capacity. Such notice shall advise all such patients to seek the services of another practitioner of good standing of their own choice.

(2) All health care facilities where such practitioner has privileges have been informed of the suspension order.

(3) Reasonable arrangements were made for the transfer of patient records, studies and test results, or copies thereof, to a succeeding practitioner employed by the patient or those responsible for the patient's care.

(4) The following organizations and governmental agencies have been notified in writing, by first class mail, of the suspension of the practitioner's license:

(A) Indiana family and social services administration.

(B) Social Security Administration.

(C) The boards or equivalent agency of each state in which the person is licensed to practice optometry.

(D) The Association of Regulatory Boards of Optometry.

(b) Proof of compliance with this section shall be a condition precedent to reinstatement. *(Indiana Optometry Board; 852 IAC 1-13-2; filed May 11, 1987, 9:00 a.m.: 10 IR 1879; readopted filed Jul 10, 2001, 3:00 p.m.: 24 IR 4238)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on November 13, 2002 at 9:20 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 10, Indianapolis, Indiana the Indiana Optometry Board will hold a public hearing on proposed rules concerning license revocation, license suspension, and duties of licensees. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W041 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Lisa R. Hayes
Executive Director
Health Professions Bureau

TITLE 852 INDIANA OPTOMETRY BOARD

Proposed Rule
LSA Document #02-133

DIGEST

Adds 852 IAC 1-17 concerning application, examination, and renewal requirements for a limited license. Effective 30 days after filing with the secretary of state.

852 IAC 1-17

SECTION 1. 852 IAC 1-17 IS ADDED TO READ AS FOLLOWS:

Rule 17. Limited License

852 IAC 1-17-1 Application file; contents

Authority: IC 25-24-1-1
Affected: IC 25-24-1-3.2

Sec. 1. (a) An applicant for a limited license shall submit the following:

(1) An application filed on a form prescribed by the Indiana optometry board and provided by the health professions bureau.

(2) The fee required by 852 IAC 1-10-1.

(3) Official transcripts, certified by the school, recording courses, grades, certificates, and degrees earned in an accredited optometry school. If not in English, the applicant must provide an official translation.

(4) One (1) passport-quality photograph taken not earlier

than one (1) year prior to the date of application, dated and signed on the back in the applicant's handwriting, "I certify that this is a true photograph of me.".
(5) A copy of the applicant's curriculum vitae.
(6) A statement from the dean at Indiana University, which includes the dates of faculty appointment and subject or subjects being taught.
(7) Verification of license status directly from the appropriate agency in each state or country where the applicant holds or has held a license to practice optometry.
(8) Verification of areas of examination, type of examination, pass-fail criteria, and the applicant's score in each area of the examination directly from the state or country in which the applicant took the examination.

(b) The dean at Indiana University school of optometry may be contacted in order to validate suitability of the applicant for a limited license. *(Indiana Optometry Board; 852 IAC 1-17-1)*

852 IAC 1-17-2 Written examination
Authority: IC 25-24-1-1
Affected: IC 25-24-1-3

Sec. 2. An applicant for a limited license must pass a written examination on the Indiana optometry statute (IC 25-24) and rules (this title). A score of seventy-five (75) or above is passing. *(Indiana Optometry Board; 852 IAC 1-17-2)*

852 IAC 1-17-3 Renewal of a limited license
Authority: IC 25-24-1-1
Affected: IC 25-24-1-3

Sec. 3. All limited license holders are required to complete thirty (30) hours of continuing education every biennium as specified in 852 IAC 1-16-1. *(Indiana Optometry Board; 852 IAC 1-17-3)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on November 13, 2002 at 9:25 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 10, Indianapolis, Indiana the Indiana Optometry Board will hold a public hearing on proposed new rules concerning application, examination, and renewal of a limited license. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W041 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Lisa R. Hayes
Executive Director
Health Professions Bureau

TITLE 856 INDIANA BOARD OF PHARMACY

Proposed Rule
LSA Document #01-306

DIGEST

Adds 856 IAC 2-7 concerning limited permits for humane societies, animal control agencies, or governmental entities operating an animal shelter; and storage, security, policy, and procedure for access, handling, and administration of Ketamine, Ketamine products, Tiletimine, and Zolazepam, and other controlled substances obtained under the limited permit. Effective 30 days after filing with the secretary of state.

856 IAC 2-7

SECTION 1. 856 IAC 2-7 IS ADDED TO READ AS FOLLOWS:

Rule 7. Limited Permits

856 IAC 2-7-1 Application
Authority: IC 35-48-3-2
Affected: IC 35-48-3-2

Sec. 1. (a) A humane society, animal control agency, or governmental entity that intends to operate an animal shelter or other animal impounding facility for the purpose of buying, possessing, and using drugs authorized by IC 35-48-3-2 shall apply for a limited permit in the form and manner required by the board.

(b) The applicant shall provide the following:
(1) Name and address of the facility.
(2) Type of facility.
(3) Documentation describing the ownership of the facility.
(4) Fees set by the board in this rule.
(5) Information about the substances that the facility intends to administer.
(6) Written policies relating to storage, security, and procedures for access, handling, and administration of drugs.
(7) Proof that the employees of the applicant who will handle a controlled substance are sufficiently trained to use and administer the controlled substance.
(8) Proof that a licensed Indiana veterinarian holding a valid Indiana controlled substances registration and federal D.E.A. registration has been retained to provide technical advice to the facility.

(c) No humane society, animal control agency, or governmental entity that intends to operate an animal shelter or other animal impounding facility for the purpose of buying, possessing, and using drugs authorized by IC 35-48-3-2

shall engage in any activity for which a permit is required until the permit is granted by the board. *(Indiana Board of Pharmacy; 856 IAC 2-7-1)*

856 IAC 2-7-2 Permit fees
Authority: IC 35-48-3-2
Affected: IC 35-48-3-2

Sec. 2. The board shall charge and collect the following fees:

Application for a limited permit	**$50**
Annual renewal of limited permit	**$25**

(Indiana Board of Pharmacy; 856 IAC 2-7-2)

856 IAC 2-7-3 Renewal of permit
Authority: IC 35-48-3-2
Affected: IC 35-48-3-2

Sec. 3. The renewal of the limited permits issued under this section shall be on the same schedule as other humane societies, animal control agencies, or governmental entities that hold controlled substance registrations issued by the board. *(Indiana Board of Pharmacy; 856 IAC 2-7-3)*

856 IAC 2-7-4 Storage, handling, and use of controlled substances
Authority: IC 35-48-3-2
Affected: IC 35-48-3-2

Sec. 4. (a) Limited permit holders and their agents, representatives, and employees must comply with the requirements of this rule for the storage and handling of controlled substances.

(b) All facilities at which controlled substances are stored, handled, or used shall:
(1) be of suitable size and construction to facilitate cleaning, maintenance, and proper operations;
(2) have storage areas large enough to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions;
(3) have a quarantine area for storage of controlled substances that are:
(A) outdated, damaged, deteriorated, misbranded, or adulterated; or
(B) in immediate or sealed secondary containers that have been opened;
(4) be maintained in a clean and orderly condition; and
(5) be free from infestation by insects, rodents, birds, or vermin of any kind.

(c) All facilities used for storage of controlled substances by registrants under this section shall comply with the security requirements as provided by 856 IAC 2-3-31.

(d) All controlled substances shall be stored at appropriate temperatures and under appropriate conditions in accordance with requirements, if any, in the labeling of such controlled substances, or with requirements in the current edition of an official compendium of drug information.

(e) If no storage requirements are established for a controlled substance, the controlled substance may be held at a controlled room temperature, as defined in an official compendium, to help ensure that its identity, strength, quality, and purity are not adversely affected.

(f) Controlled substances that are outdated, damaged, deteriorated, misbranded, or adulterated shall be quarantined and physically separated from other controlled substances until they are destroyed by a designated agent of the board or returned to their supplier.

(g) Any controlled substance whose immediate or sealed outer or sealed secondary containers have been opened or used shall be:
(1) identified as such; and
(2) quarantined and physically separated from other controlled substances until they are either destroyed by a designated agent of the board or returned to the supplier.

(h) Limited permit holders shall establish and maintain inventories and records of all controlled substances stored or used at the facility.

(i) Inventories and records shall be made available for inspection and photocopying by any authorized official of any governmental agency charged with enforcement of this rule for a period of two (2) years following disposition of the controlled substances.

(j) Records described in this section that are kept at the inspection site or that can be immediately retrieved by computer or other electronic means shall be readily available for authorized inspection during the retention period. Records kept at a central location apart from the inspection site and not electronically retrievable shall be made available for inspection within two (2) working days of a request by an authorized official of any governmental agency charged with enforcement of this rule. *(Indiana Board of Pharmacy; 856 IAC 2-7-4)*

856 IAC 2-7-5 Training of staff
Authority: IC 35-48-3-2
Affected: IC 35-48-3-2

Sec. 5. (a) Only employees of the limited permit holder are eligible for training to store, handle, and use controlled substances. Volunteers are prohibited from storing, handling, or using controlled substances.

(b) The following training is required:
(1) Completion of a comprehensive training program

approved by the controlled substance advisory committee.
(2) Any additional training as required by the supervising veterinarian or site administrator.

(c) A veterinarian licensed to practice in Indiana, holding a valid Indiana controlled substances registration and federal D.E.A. registration, must verify in writing that the employee has been trained adequately to store, handle, or use controlled substances. The written verification must be maintained at the facility in a reasonably retrievable manner.

(d) The limited permit holder or site administrator shall maintain documentary proof of training in a reasonably retrievable manner at the facility for review by an authorized official of any governmental agency charged with enforcement of this rule. *(Indiana Board of Pharmacy; 856 IAC 2-7-5)*

856 IAC 2-7-6 Protocol for administration of controlled substances
Authority: IC 35-48-3-2
Affected: IC 35-48-3-2

Sec. 6. In the event the consulting veterinarian is not physically present during the administration of controlled substances by employees of the limited permit holder, the veterinarian shall be available for consultation by telephonic or other electronic device. *(Indiana Board of Pharmacy; 856 IAC 2-7-6)*

856 IAC 2-7-7 Limitations on permit
Authority: IC 35-48-3-2
Affected: IC 35-48-3-2

Sec. 7. (a) Except as provided in subsection (b), only controlled substances for which the humane society, animal control agency, or governmental entity has received a permit may be stored, handled, and used at the facility.

(b) A licensed veterinarian who stores, handles, or uses controlled substances at the humane society, animal control agency, or governmental entity other than those authorized under the facility's limited permit must apply for and obtain a controlled substance registration for the facility in the veterinarian's name.

(c) The veterinarian who holds the registration noted in subsection (b) is responsible for the proper storage, handling, and use of the controlled substances authorized for use under the veterinarian's controlled substance registration. *(Indiana Board of Pharmacy; 856 IAC 2-7-7)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on August 27, 2002 at 9:30 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 7, Indianapolis, Indiana the Indiana Board of Pharmacy will hold a public hearing on proposed new rules to provide regulations on a limited permit for animal shelters to handle Ketamine and other products. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W041 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Lisa R. Hayes
Executive Director
Health Professions Bureau

TITLE 857 INDIANA OPTOMETRIC LEGEND DRUG PRESCRIPTION ADVISORY COMMITTEE

Proposed Rule
LSA Document #02-123

DIGEST

Amends 857 IAC 2-3-16 concerning formulary of legend drugs listed by category. Effective 30 days after filing with the secretary of state.

857 IAC 2-3-16

SECTION 1. 857 IAC 2-3-16 IS AMENDED TO READ AS FOLLOWS:

857 IAC 2-3-16 Formulary of legend drugs listed by category
Authority: IC 25-26-15-13
Affected: IC 35-48-1

Sec.16. (a) **Any** legend ~~drugs that fall into the following categories are independent~~ **drug** for ~~treating~~ the **treatment of the** eye or associated structures of the eye.
~~(1) Topically applied drugs.~~
~~(2) Oral antihistamine drugs.~~
~~(3) Oral decongestant drugs.~~
~~(4) Oral antimicrobial drugs.~~
~~(5) Oral nonsteroidal anti-inflammatory drugs (NSAIDs).~~
~~(6) Oral antiglaucoma drugs.~~
~~(7) Oral analgesics, which may be prescribed for a period of time not to exceed five (5) days.~~

(b) Controlled substances as defined in IC 35-48-1 are prohibited from use by an optometrist. *(Indiana Optometric Legend Drug Prescription Advisory Committee; 857 IAC 2-3-16; filed Feb 4, 1994, 5:00 p.m.: 17 IR 1099; filed Jun 30, 1999, 2:45 p.m.: 22 IR 3414; readopted filed Apr 24, 2001, 10:21 a.m.: 24 IR 2896)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on September 4, 2002 at 10:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 8, Indianapolis, Indiana the Indiana Optometric Legend Drug Prescription Advisory Committee will hold a public hearing on proposed amendments concerning fees related to the practice of pharmacy. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W041 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Lisa R. Hayes
Executive Director
Health Professions Bureau

TITLE 876 INDIANA REAL ESTATE COMMISSION

Proposed Rule
LSA Document #01-427

DIGEST

Amends 876 IAC 1-1-23 to establish the requirements and procedures for the listing and selling principal broker to release earnest monies when one or more parties to a contract intends to perform. Amends 876 IAC 1-4-2 to revise the seller's residential real estate sales disclosure form. Amends 876 IAC 4-1-3 to allow continuing education courses once approved through continuing education sponsors to be used by other sponsors without further approval. Effective 30 days after filing with the secretary of state.

876 IAC 1-1-23
876 IAC 1-4-2
876 IAC 4-1-3

SECTION 1. 876 IAC 1-1-23, AS AMENDED AT 25 IR 102, SECTION 2, IS AMENDED TO READ AS FOLLOWS:

876 IAC 1-1-23 Written offers to purchase; disposition of money received

Authority: IC 25-34.1-2-5
Affected: IC 25-34.1-2-5

Sec. 23. **(a)** Any and all written offers to purchase or authorization to purchase shall be communicated to the seller for his or her formal acceptance or rejection immediately upon receipt of such offer, and such offers or authorizations shall be made in quadruplicate, one (1) copy to the prospective purchasers at the time of signing, one (1) copy for the principal broker's files, one (1) copy to the sellers, and one (1) copy to be returned to the purchasers after acceptance or rejection. The listing principal broker shall, on or before the next two (2) banking days after acceptance of the offer to purchase by the seller, do one (1) of the following:

(1) Deposit all money received in connection with a transaction in his or her escrow/trust account.

(2) Delegate the responsibility to the selling principal broker to deposit the money in the selling broker's escrow/trust account. In any event, the commission shall hold the listing principal broker responsible for the money.

In the event the earnest money deposit is other than cash, this fact shall be communicated to the seller prior to his or her acceptance of the offer to purchase, and such fact shall be shown in the earnest money receipt. All money shall be retained in the escrow/trust account so designated until disbursement thereof is properly authorized. The listing ~~and~~ **or** selling principal brokers holding any earnest money are not required to make payment to the purchasers or sellers when a real estate transaction is not consummated unless the parties enter into a mutual release of the funds or a court issues an order for payment, **except as permitted in subsection (b).**

(b) Upon being notified that one (1) or more parties to an offer to purchase intends not to perform, the listing or selling principal broker, holding the earnest money, may release the earnest money deposit as provided in the offer to purchase or if no provision is made in the offer to purchase, the selling or listing principal, holding the earnest money, may initiate the release process. The release process shall require the selling or listing principal broker to notify all parties at their last known address by certified mail that the earnest money deposit shall be distributed to the parties specified in the letter unless:

(1) all parties enter into a mutual release; or

(2) one (1) or more of the parties initiate litigation;

within sixty (60) days of the mailing date of the certified letter. If neither buyer or seller initiates litigation or enters into a written release within sixty (60) days of the mailing date of the certified letter, the broker may release the earnest money deposit to the party identified in the certified letter. *(Indiana Real Estate Commission; Rule 24; filed Sep 28, 1977, 4:30 p.m.: Rules and Regs. 1978, p. 800; filed Dec 11, 1986, 10:40 a.m.: 10 IR 878; readopted filed Jun 29, 2001, 9:56 a.m.: 24 IR 3824; filed Aug 15, 2001, 9:50 a.m.: 25 IR 102)*

SECTION 2. 876 IAC 1-4-2 IS AMENDED TO READ AS FOLLOWS:

876 IAC 1-4-2 Residential sales disclosure; form

Authority: IC 24-4.6-2-7
Affected: IC 24-4.6-2

Sec. 2. The following is the seller's residential real estate sales disclosure form:

SELLER'S RESIDENTIAL REAL ESTATE SALES DISCLOSURE
State Form 46234 (R/1293)

Date (*month, day, year*)

Seller states that the information contained in this Disclosure is correct to the best of Seller's CURRENT ACTUAL KNOWLEDGE as of the above date. The prospective buyer and the owner may wish to obtain professional advice or inspections of the property and provide for appropriate provisions in a contract between them concerning any advice, inspections, defects, or warranties obtained on the property. The representations in this form are the representations of the owner and are not the representations of the agent, if any. This information is for disclosure only and is not intended to be a part of any contract between the buyer and the owner. Indiana law (IC 24-4.6-2) generally requires sellers of 1-4 unit residential property to complete this form regarding the known physical condition of the property. An owner must complete and sign the disclosure form and submit the form to a prospective buyer before an offer is accepted for the sale of the real estate.

Property address (*number and street, city, state, ZIP code*)

1. The following are in the conditions indicated:

A. APPLIANCES	None/Not Included	Defective	Not Defective	Do Not Know
Built-in Vacuum System				
Clothes Dryer				
Clothes Washer				
Dishwasher				
Disposal				
Freezer				
Gas Grill				
Hood				
Microwave Oven				
Oven				
Range				
Refrigerator				
Room Air Conditioner(s)				
Trash Compactor				
TV Antenna/Dish				
Other:				

B. ELECTRICAL SYSTEM	None/Not Included	Defective	Not Defective	Do Not Know
Air Purifier				
Burglar Alarm				
Ceiling Fan(s)				
Garage Door Opener Controls				
Inside Telephone Wiring and Blocks/Jacks				
Intercom				
Light Fixtures				
Sauna				
Smoke/Fire Alarm(s)				
Switches and Outlets				
Vent Fan(s)				
60/100/200 Amp Service (Circle one)				

NOTE: "Defect" means a condition that would have a significant adverse effect on the value of the property that would significantly impair the health or safety of future occupants of the property, or that if not repaired, removed, or replaced would significantly shorten or adversely affect the expected normal life of the premises.

C. WATER & SEWER SYSTEM	None/Not Included	Defective	Not Defective	Do Not Know
Cistern				
Septic Field/Bed				
Hot Tub				
Plumbing				
Aerator System				
Sump Pump				
Irrigation Systems				
Water Heater/Electric				
Water Heater/Gas				
Water Heater/Solar				
Water Purifier				
Water Softener				
Well				
Other Sewer System (Explain)				

	Yes	No	Do Not Know
Are the improvements connected to a public water system?			
Are the improvements connected to a public sewer system?			
Are there any additions that may require improvements to the sewage disposal system?			
If yes, have the improvements been completed on the sewage disposal system?			
Are the improvements connected to a private/community water system?			
Are the improvements connected to a private/community sewer system?			

D. HEATING & COOLING SYSTEM	None/Not Included	Defective	Not Defective	Do Not Know
Attic Fan				
Central Air Conditioning				
Hot Water Heat				
Furnace Heat/Gas				
Furnace Heat/Electric				
Solar House-Heating				
Woodburning Stove				
Fireplace				
Fireplace Insert				
Air Cleaner				
Humidifier				
Propane Tank				
Other Heating Source				

2. ROOF	YES	NO	DO NOT KNOW
Age, if known: _____ Years			
Does the roof leak?			
Is there present damage to the roof?			
Is there more than one roof on the house? If so, how many ~~roofs?~~ **layers?**			

3. HAZARDOUS CONDITIONS	YES	NO	DO NOT KNOW
Have there been or are there any ~~existing~~ hazardous conditions on the property, such as methane gas, lead paint, radon gas in house or well, radioactive material, landfill, mineshaft, expansive soil, toxic materials, **mold, other biological contaminants,** asbestos insulation, or PCB's? **Explain:**			

4. OTHER DISCLOSURES	YES	NO	DO NOT KNOW
Do improvements have aluminum wiring?			
Are there any foundation problems with the improvements?			
Are there any encroachments?			
Are there any violations of zoning, building codes, or restrictive covenants?			
Is the present use a nonconforming use? Explain:			
Have you received any notices by any governmental or quasi-governmental agencies affecting this property? Are there any structural problems with the building?			
Have any substantial additions or alterations been made without a required building permit?			
Are there moisture and/or water problems in the basement, ~~or~~ crawl space area, **or any other area?**			
Is there any damage due to wind, flood, termites, or rodents?			
Have any improvements been treated for wood destroying insects?			
Are the furnace/woodstove/chimney/flue all in working order?			
Is the property in a flood plain?			
Do you currently pay flood insurance?			
Does the property contain underground storage tank(s)?			
Is the ~~seller~~ **homeowner** a licensed real estate salesperson or broker?			
Is there any threatened or existing litigation regarding the property?			
Is the property subject to covenants, conditions, and/or restrictions of a homeowner's association?			
Is the property located within one (1) mile of an airport?			

E. ADDITIONAL COMMENTS AND/OR EXPLANATIONS: (Use additional pages if necessary).

The information contained in this Disclosure has been furnished by the Seller, who certifies to the truth thereof, based on the Seller's CURRENT ACTUAL KNOWLEDGE. A disclosure form is not a warranty by the owner or the owner's agent, if any, and the disclosure form may not be used as a substitute for any inspections or warranties that the prospective buyer or owner may later obtain. At or before settlement, the owner is required to disclose any material change in the physical condition of the property or certify to the purchaser at settlement that the condition of the property is substantially the same as it was when the disclosure form was provided. Seller and Purchaser hereby acknowledge receipt of this Disclosure by signing below:

Signature of Seller	Date	Signature of Buyer	Date
Signature of Seller	Date	Signature of Buyer	Date

The seller hereby certifies that the condition of the property is substantially the same as it was when the Seller's Disclosure form was originally provided to the Buyer.

Signature of Seller	Date	Signature of Seller	Date

(Indiana Real Estate Commission; 876 IAC 1-4-2; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2352; filed Jun 14, 1995, 11:00 a.m.: 18 IR 2787; readopted filed Jun 29, 2001, 9:56 a.m.: 24 IR 3824)

SECTION 3. 876 IAC 4-1-3, AS AMENDED AT 25 IR 103, SECTION 6, IS AMENDED TO READ AS FOLLOWS:

876 IAC 4-1-3 Significant changes

Authority: IC 25-34.1-9-21
Affected: IC 25-34.1

Sec. 3. (a) Any significant changes in the operation of the approved sponsor must be approved by the commission prior to the effective date of the change. Any change in the course outline must be approved by the commission prior to the course being offered or given. The commission shall review the changes to determine whether or not the sponsor shall continue to be approved.

(b) Significant changes shall include the following:

(1) Change in ownership of the sponsor, including changes in the officers and directors of the corporation.

(2) A new school director.
(3) A new instructor.
(4) Any change in course outline.

(c) Once a continuing education instructor ~~has~~ **and course outline have** been approved through the continuing education sponsor, the instructor ~~is~~ **and the course outline are** approved ~~to teach~~ for all continuing education sponsors. **It shall be the responsibility of the continuing education sponsor to ensure that the commission has previously approved the course outline.**

(d) Notwithstanding subsection (b)(3), an instructor who has already been approved under this section or section 2 of this rule for another approved sponsor shall not be considered a new instructor. *(Indiana Real Estate Commission; 876 IAC 4-1-3; filed Dec 1, 1993, 10:30 a.m.: 17 IR 766; filed Jun 14, 1995, 11:00 a.m.: 18 IR 2790; readopted filed Jun 29, 2001, 9:56 a.m.: 24 IR 3824; filed Aug 15, 2001, 9:50 a.m.: 25 IR 103)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on August 22, 2002 at 10:30 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 4, Indianapolis, Indiana the Indiana Real Estate Commission will hold a public hearing on proposed amendments to establish the requirements and procedures for the listing and selling principal broker to release earnest monies when one or more parties to a contract intends to perform, to revise the seller's residential real estate sales disclosure form, and to allow continuing education courses once approved through continuing education sponsors to be used by other sponsors without further approval. Copies of these rules are now on file at the Indiana Government Center-South, 302 West Washington Street, Room E012 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Gerald H. Quigley
Executive Director
Indiana Professional Licensing Agency

TITLE 888 INDIANA BOARD OF VETERINARY MEDICAL EXAMINERS

Proposed Rule
LSA Document #02-134

DIGEST

Amends 888 IAC 1.1-6-1 concerning the application content, the examination of applicants, and the deadline for applying to take the examination for licensure. Effective 30 days after filing with the secretary of state.

888 IAC 1.1-6-1

SECTION 1. 888 IAC 1.1-6-1 IS AMENDED TO READ AS FOLLOWS:

888 IAC 1.1-6-1 Application content; examination applicant; application deadline

Authority: IC 15-5-1.1-8
Affected: IC 15-5-1.1-11; IC 15-5-1.1-12

Sec. 1. (a) An applicant for license by examination shall submit the following information:
(1) Official transcripts or a letter from the dean, certified by the school or college, recording the degree earned in a school or college of veterinary medicine accredited under IC 15-5-1.1-11(a) or a notarized copy of the applicant's diploma.
(2) Official score report of the applicant's National Board Examination (NBE) and the Clinical Competency Test (CCT) or the North American Veterinary Licensing Examination (NAVLE) approved under IC 15-5-1.1-12(b) if the applicant is not applying to take these examinations in Indiana.
(3) Two (2) unmounted, duplicate, passport-quality photographs taken not earlier than eight (8) weeks prior to the date of application, dated and signed across the back in the applicant's handwriting, "I certify that this is a true photograph of me.".
(4) A statement from the appropriate agency in each state where the applicant has been licensed, verifying the date the applicant's license was originally issued and certifying whether or not disciplinary proceedings have ever been initiated or are presently pending against the applicant.
(5) The fee required by 888 IAC 1.1-3-2.

(b) An applicant who has not graduated from an accredited school of veterinary medicine and who submits satisfactory proof that he or she is participating in an Educational Commission for Foreign Veterinary Graduates (ECFVG) program of the American Veterinary Medical Association may take the NAVLE. The applicant is not eligible for licensure until he or she submits satisfactory proof that he or she holds an ECFVG certificate issued by the American Veterinary Medical Association.

(c) All applications for the NAVLE must be received by the board at least seventy-five (75) days prior to the administration of the NAVLE in which the applicant desires to participate. *(Indiana Board of Veterinary Medical Examiners; 888 IAC 1.1-6-1; filed Jan 22, 1991, 4:50 p.m.: 14 IR 1284; filed Dec 27, 1993, 9:00 a.m.: 17 IR 1004; filed Aug 7, 2000, 2:19 p.m.: 24 IR 24; readopted filed Jul 18, 2001, 10:20 a.m.: 24 IR 4238)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on October 30, 2002 at 9:15 a.m., at the Indiana Government Center-South,

402 West Washington Street, Conference Center Room 12, Indianapolis, Indiana the Indiana Board of Veterinary Medical Examiners will hold a public hearing on proposed amendments concerning the application content, the examination of applicants, and the deadline for applying to take the examination for licensure. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W041 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Lisa R. Hayes
Executive Director
Health Professions Bureau

TITLE 888 INDIANA BOARD OF VETERINARY MEDICAL EXAMINERS

Proposed Rule
LSA Document #02-135

DIGEST

Amends 888 IAC 1.1-6-3 concerning examination scores and remedial education. Effective 30 days after filing with the secretary of state.

888 IAC 1.1-6-3

SECTION 1. 888 IAC 1.1-6-3 IS AMENDED TO READ AS FOLLOWS:

888 IAC 1.1-6-3 Examination scores; remedial education
Authority: IC 15-5-1.1-8
Affected: IC 15-5-1.1

Sec. 3. (a) An applicant for licensure is required to attain a passing score on the National Board Examination (NBE) and the Clinical Competency Test (CCT) or the North American Veterinary Licensing Examination (NAVLE).

(b) An applicant is required to attain a score of seventy-five (75) or above on a written examination on jurisprudence.

(c) An applicant who attains a score of seventy-five (75) or above on the written examination on jurisprudence and a passing score on the CCT and the NBE or the NAVLE shall pass the examination.

(d) An applicant who has taken the NBE and CCT or the NAVLE in another state is not required to retake those examinations, provided the applicant has attained a passing score on the examinations.

(e) An applicant who attains a score below seventy-five (75) on the written examination on jurisprudence or a score below passing on the NBE, CCT, or NAVLE shall fail the examination and must repeat the examination on which a passing score was not attained.

(f) The applicable fee shall be charged for each examination or reexamination.

(g) After three (3) or more failures in Indiana or in another state, an applicant may not retake the NAVLE in Indiana unless the applicant completes courses of additional study as specified by the board at an institution approved by the board. Upon completion of additional study, the board may permit a candidate to retake the NAVLE examination. *(Indiana Board of Veterinary Medical Examiners; 888 IAC 1.1-6-3; filed Jan 22, 1991, 4:50 p.m.: 14 IR 1284; filed Apr 12, 1993, 11:00 a.m.: 16 IR 2188; filed Dec 27, 1993, 9:00 a.m.: 17 IR 1005; filed Aug 7, 2000, 2:19 p.m.: 24 IR 25; readopted filed Jul 18, 2001, 10:20 a.m.: 24 IR 4238)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on October 30, 2002 at 9:20 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 12, Indianapolis, Indiana the Indiana Board of Veterinary Medical Examiners will hold a public hearing on proposed rules concerning examination scores and remedial education. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W041 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Lisa R. Hayes
Executive Director
Health Professions Bureau

TITLE 888 INDIANA BOARD OF VETERINARY MEDICAL EXAMINERS

Proposed Rule
LSA Document #02-136

DIGEST

Adds 888 IAC 1.1-11 concerning inactive status of licenses to practice veterinary medicine and inactive status of registered veterinary technicians. Effective 30 days after filing with the secretary of state.

888 IAC 1.1-11

SECTION 1. 888 IAC 1.1-11 IS ADDED TO READ AS FOLLOWS:

Rule 11. Inactive Status of Licenses

888 IAC 1.1-11-1 Inactive status for veterinarians
Authority: IC 15-5-1.1-8
Affected: IC 15-5-1.1-18; IC 15-5-1.1-19

Sec. 1. (a) The board may place a veterinary license on inactive status if the applicant makes the request in writing at the time licenses are eligible for renewal under IC 15-5-1.1-18.

(b) The fee and continuing education requirements are waived when a request for inactive status is submitted.

(c) The veterinarian will no longer receive renewal notices until the time the veterinarian submits a written request to reactivate the veterinarian's license. *(Indiana Board of Veterinary Medical Examiners; 888 IAC 1.1-11-1)*

888 IAC 1.1-11-2 Reactivation of an inactive license to practice veterinary medicine; requirements
Authority: IC 15-5-1.1-8
Affected: IC 15-5-1.1-18; IC 15-5-1.1-19

Sec. 2. (a) The following requirements apply to requests for reactivation of an inactive license to practice veterinary medicine:

(1) The veterinarian must submit an application for reactivation in the form and manner required by the board.

(2) The veterinarian must submit the current renewal fee as required in 888 IAC 1.1-3-2 at the time of applying to reactivate the applicant's license.

(3) If the veterinarian's license has been on inactive status two (2) years or less, the veterinarian must submit proof of all required continuing education hours as required by 888 IAC 1.1-10-1.

(4) If the veterinarian's license has been on inactive status for more than two (2) years up to and including three (3) years, the veterinarian must submit proof of completion of sixty (60) hours of the continuing education that meets the requirements of 888 IAC 1.1-10-1.

(5) If the veterinarian's license has been on inactive status more than three (3) years up to and including four (4) years, the veterinarian must submit proof of completion of eighty (80) hours of the continuing education that meets the requirements of 888 IAC 1.1-10-1.

(6) If the veterinarian's license has been inactive more than four (4) years, the board may require the veterinarian to make a personal appearance and meet the conditions set by the Board, including completion of continuing education in an amount prescribed by the board. The veterinarian may be required to take and pass an examination as approved by the board.

(b) Documentation verifying the completion of the continuing education programs must be submitted to the board with the license reactivation application. *(Indiana Board of Veterinary Medical Examiners; 888 IAC 1.1-11-2)*

888 IAC 1.1-11-3 Inactive status for registered veterinary technicians
Authority: IC 15-5-1.1-8
Affected: IC 15-5-1.1-18; IC 15-5-1.1-19

Sec. 3. (a) The board may place a registered veterinary technician on inactive status if the applicant makes the request in writing at the time licenses are eligible for renewal under IC 15-5-1.1-18.

(b) The fee and continuing education requirements are waived when a request for inactive status is submitted.

(c) The registered veterinary technician will no longer receive renewal until the time the registered veterinary technician submits a written request to reactivate the veterinary technician's registration. *(Indiana Board of Veterinary Medical Examiners; 888 IAC 1.1-11-3)*

888 IAC 1.1-11-4 Reactivation of an inactive veterinary technician registration
Authority: IC 15-5-1.1-8
Affected: IC 15-5-1.1-18; IC 15-5-1.1-19

Sec. 4. (a) The following requirements apply to requests for reactivation of an inactive veterinary technician registration:

(1) The veterinary technician must submit an application for reactivation in the form and manner required by the board.

(2) The registered veterinary technician must submit the current renewal fee as required in 888 IAC 1.1-3-3 at the time of applying to reactivate the applicant's registration.

(3) If the registered veterinary technician's registration has been on inactive status two (2) years or less, the registered veterinary technician must submit proof of completion of all required continuing education hours as required by 888 IAC 1.1-10-1.

(4) If the registered veterinary technician has been on inactive status more than two (2) years up to and including three (3) years, the registered veterinary technician must submit proof of completion of twenty-four (24) hours of the continuing education that meets the requirements of 888 IAC 1.1-10-1.

(5) If the registered veterinary technician has been on inactive status more than three (3) years up to and

including four (4) years, the registered veterinary technician must submit proof of completion of thirty-two (32) hours of the continuing education that meets the requirements of 888 IAC 1.1-10-1.

(6) If the registered veterinary technician has been on inactive status more than four (4) years, the board may require the registered veterinary technician to make a personal appearance and meet the conditions set by the board, including the completion of continuing education in an amount prescribed by the board. The registered veterinary technician may be required to take and pass an examination as approved by the board.

(b) Documentation verifying the completion of the continuing education programs must be submitted to the board with the registration reactivation application. *(Indiana Board of Veterinary Medical Examiners; 888 IAC 1.1-11-4)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on October 30, 2002 at 9:25 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 12, Indianapolis, Indiana the Indiana Board of Veterinary Medical Examiners will hold a public hearing on proposed new rules concerning inactive status for veterinarians and registered veterinary technicians, and reactivation of an inactive license. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W041 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Lisa R. Hayes
Executive Director
Health Professions Bureau