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Submissions for Review

Within 10 calendar days after adoption by an agency of a proposed PERMANENT rulemaking action, the agency must submit the proposed rules to the Governor and the Legislature for review. In addition, the agency must publish in the *Register* a "statement" that the rules have been submitted for gubernatorial/legislative review.

For additional information on submissions for gubernatorial/legislative review, see 75 O.S., Section 303.1, 303.2, and 308.

TITLE 10. OKLAHOMA ACCOUNTANCY BOARD CHAPTER 15. LICENSURE AND REGULATION OF ACCOUNTANCY

[OAR Docket #07-525]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- Subchapter 1. General Provisions
- 10:15-1-2 [AMENDED]
- Subchapter 25. Permits
- 10:15-25-3 [AMENDED]
- Subchapter 30. Continuing Professional Education
- 10:15-30-5 [AMENDED]
- 10:15-30-8 [AMENDED]
- Subchapter 32. Standards for Continuing Professional Education (CPE) Programs
- 10:15-32-5 [AMENDED]
- Subchapter 33. Peer Review
- 10:15-33-4 [AMENDED]
- 10:15-33-6 [AMENDED]
- 10:15-33-7 [AMENDED]
- Subchapter 39. Rules of Professional Conduct
- 10:15-39-1 [AMENDED]
- 10:15-39-9 [AMENDED]

SUBMITTED TO GOVERNOR:

March 27, 2007

SUBMITTED TO HOUSE:

March 27, 2007

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March 27, 2007

[OAR Docket #07-525; filed 3/27/07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 2. FEES

[OAR Docket #07-622]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 3. Fee Schedules
- 35:2-3-2.4 [AMENDED]
- 35:2-3-2.6 [AMENDED]
- 35:2-3-2.7 [AMENDED]
- 35:2-3-2.8 [AMENDED]

SUBMITTED TO GOVERNOR:

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March 26, 2007

[OAR Docket #07-622; filed 4-2-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 2. FEES

[OAR Docket #07-623]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 3. Fee Schedules
- 35:2-3-12 [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-623; filed 4-2-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 2. FEES

[OAR Docket #07-624]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 3. Fee Schedules
- 35:2-3-29 [AMENDED]

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[OAR Docket #07-624; filed 4-2-07]

Submissions for Review

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 3. FINE MATRICES

[OAR Docket #07-625]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. Fine Schedules

Part 15. ~~Plant and Consumer~~ Protection Services Violations
35:3-1-18 [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-625; filed 4-2-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 10. AGRICULTURAL PRODUCTS

[OAR Docket #07-626]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 7. Public Warehouses
35:10-7-15 [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-626; filed 4-2-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 13. FUEL ALCOHOL

[OAR Docket #07-627]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

35:13-1-1 [AMENDED]

35:13-1-2 [AMENDED]

35:13-1-4 [AMENDED]

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[OAR Docket #07-627; filed 4-2-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 15. ANIMAL INDUSTRY

[OAR Docket #07-609]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 44. Farmed Cervidae [NEW]

35:15-44-1 through 35:35-15-44-19 [NEW]

35:15-44-20 [RESERVED]

SUBMITTED TO GOVERNOR:

February 16, 2007

SUBMITTED TO HOUSE:

February 16, 2007

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February 16, 2007

[OAR Docket #07-609; filed 3-30-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 15. ANIMAL INDUSTRY

[OAR Docket #07-628]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Animal Health Reportable Diseases

35:15-3-1 [AMENDED]

35:15-3-2 [AMENDED]

35:15-3-3 [REVOKED]

35:15-3-4 [AMENDED]

SUBMITTED TO GOVERNOR:

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March 26, 2007

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March 26, 2007

[OAR Docket #07-628; filed 4-2-07]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 15. ANIMAL INDUSTRY**

[OAR Docket #07-629]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 13. Testing and Inspection for Disease and Release of Livestock at Auction Markets

35:15-13-3 [AMENDED]

Subchapter 15. Equine Infectious Anemia (EIA)

Part 3. Procedures

35:15-15-34 [AMENDED]

Part 7. Requirements for Approved Markets

35:15-15-71 [AMENDED]

Subchapter 17. Bovine and Bison Brucellosis

Part 1. Definitions

35:15-17-1 [AMENDED]

Part 11. Entry Permit and Retest Requirements

35:15-17-80 [AMENDED]

Subchapter 19. Poultry Regulations

35:15-19-4 [AMENDED]

35:15-19-8 [AMENDED]

Subchapter 22. Swine Pseudorabies

Part 1. General Provisions

35:15-22-3 [NEW]

Part 9. Requirements for Approved Markets

35:15-22-91 [AMENDED]

Subchapter 24. Swine Brucellosis

Part 1. General Provisions

35:15-24-3 [AMENDED]

Subchapter 36. Scrapie

35:15-36-3 [NEW]

SUBMITTED TO GOVERNOR:

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March 26, 2007

[OAR Docket #07-629; filed 4-2-07]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 15. ANIMAL INDUSTRY**

[OAR Docket #07-630]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 16. Contagious Equine Metritis

35:15-16-1 [AMENDED]

Subchapter 36. Scrapie

35:15-36-1 [AMENDED]

35:15-36-2 [AMENDED]

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[OAR Docket #07-630; filed 4-2-07]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 17. WATER QUALITY**

[OAR Docket #07-631]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Concentrated Animal Feeding Operations

35:17-3-11 [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-631; filed 4-2-07]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 17. WATER QUALITY**

[OAR Docket #07-632]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 9. Agricultural Compost Facilities [AMENDED]

35:17-9-1 [AMENDED]

35:17-9-3 [AMENDED]

35:17-9-8 [AMENDED]

SUBMITTED TO GOVERNOR:

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March 26, 2007

[OAR Docket #07-632; filed 4-2-07]

Submissions for Review

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 20. FORESTRY

[OAR Docket #07-633]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 13. Governor's Ban on Outdoor Burning
[AMENDED]

Part 1. General Provisions

35:20-13-1 [AMENDED]

35:20-13-2 [AMENDED]

35:20-13-3 [REVOKED]

Part 3. Overview of Governor's Ban on Burning

35:20-13-7 [AMENDED]

35:20-13-8 [AMENDED]

Part 5. Burning Ban Guidelines

35:20-13-13 through 35:20-13-18 [AMENDED]

35:20-13-19 [REVOKED]

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March 26, 2007

[OAR Docket #07-633; filed 4-2-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 30. PLANT INDUSTRY

[OAR Docket #07-634]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 14. Oklahoma Boll Weevil [AMENDED]

35:30-14-1 [AMENDED]

35:30-14-2 [AMENDED]

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March 26, 2007

[OAR Docket #07-634; filed 4-2-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 30. PLANT INDUSTRY

[OAR Docket #07-635]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 17. Combined Pesticide

Part 1. Commercial and Non-Commercial Categories of
Pesticide Application

35:30-17-3 [AMENDED]

35:30-17-3.1 [NEW]

35:30-17-3.2 [NEW]

35:30-17-3.3 [NEW]

Part 9. Minimum Standards for Contracts and Keeping of
Records

35:30-17-21 [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-635; filed 4-2-07]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 30. PLANT INDUSTRY

[OAR Docket #07-636]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 17. Combined Pesticide

Part 5. Prerequisites for Licensing

35:30-17-10 [AMENDED]

Part 6. Pesticidal Product Producing Establishments

35:30-17-13 [AMENDED]

Part 9. Minimum Standards for Contracts and Keeping of
Records

35:30-17-21 [AMENDED]

Part 22. Wood Infestation Reports

35:30-17-105 [AMENDED]

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March 26, 2007

[OAR Docket #07-636; filed 4-2-07]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. PLANT INDUSTRY**

[OAR Docket #07-637]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 17. Combined Pesticide
Part 21. Standards for Disposal of Pesticide and Pesticide Containers
35:30-17-89.1 [NEW]

SUBMITTED TO GOVERNOR:

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**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. PLANT INDUSTRY**

[OAR Docket #07-638]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 37. Nursery Stock Sales
35:30-37-11 [NEW]

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**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 37. FOOD SAFETY**

[OAR Docket #07-639]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Meat Inspection
Part 1. General Provisions
35:37-3-1 [AMENDED]
35:37-3-3 [AMENDED]

Subchapter 5. Poultry Products Inspection

Part 1. General Provisions

35:37-5-1 [AMENDED]

35:37-5-2 [AMENDED]

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**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 37. FOOD SAFETY**

[OAR Docket #07-640]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 13. Milk and Milk Products
35:37-13-2 [AMENDED]

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**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 44. AGRICULTURE POLLUTANT DISCHARGE ELIMINATION SYSTEM**

[OAR Docket #07-641]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Concentrated Animal Feeding Operations
35:44-3-3 [AMENDED]

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Submissions for Review

TITLE 75. ATTORNEY GENERAL CHAPTER 15. STANDARDS AND CRITERIA FOR DOMESTIC VIOLENCE, SEXUAL ASSAULT AND BATTERERS INTERVENTION PROGRAMS

[OAR Docket #07-598]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 15. Standards and Criteria For Domestic Violence,
Sexual Assault and Batters Intervention Programs
[AMENDED]

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[OAR Docket #07-598; filed 3-30-07]

TITLE 87. OKLAHOMA STATE EMPLOYEES BENEFITS COUNCIL CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #07-539]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Organization and Administration
87:1-3-12. Location for information and for filing
[AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-539; filed 3-27-07]

TITLE 87. OKLAHOMA STATE EMPLOYEES BENEFITS COUNCIL CHAPTER 15. COMPETITIVE BIDDING CRITERIA AND PROCEDURES FOR CONTRACTS AWARDED FOR FLEXIBLE BENEFITS PLANS

[OAR Docket #07-540]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

87:15-1-4. Bidder registration [AMENDED]

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[OAR Docket #07-540; filed 3-27-07]

TITLE 135. COMMISSION ON CHILDREN AND YOUTH CHAPTER 1. GENERAL COURSE AND METHOD OF OPERATION

[OAR Docket #07-616]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. General Course and Method of Operation
135:1-1-1.2 [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-616; filed 4-2-07]

TITLE 135. COMMISSION ON CHILDREN AND YOUTH CHAPTER 10. PROGRAMS, BOARDS, AND COUNCILS: OPERATION AND ADMINISTRATION

[OAR Docket #07-617]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 22. Child Abuse Training and Coordination Council [NEW]
135:10-22-1 [NEW]
135:10-22-2 [NEW]
135:10-22-3 [NEW]

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[OAR Docket #07-617; filed 4-2-07]

**TITLE 160. DEPARTMENT OF CONSUMER CREDIT
CHAPTER 45. TRUTH IN LENDING RULES**

[OAR Docket #07-570]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 9. Special Rules for Certain Home Mortgage Transactions
160:45-9-2 [AMENDED]

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[OAR Docket #07-570; filed 3-29-07]

**TITLE 160. DEPARTMENT OF CONSUMER CREDIT
CHAPTER 55. MORTGAGE BROKERS**

[OAR Docket #07-571]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Licensing
160:55-3-1.4 [AMENDED]
Subchapter 7. Records
160:55-7-1 [AMENDED]

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[OAR Docket #07-571; filed 3-29-07]

**TITLE 160. DEPARTMENT OF CONSUMER CREDIT
CHAPTER 70. DEFERRED DEPOSIT LENDERS**

[OAR Docket #07-572]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
160:70-1-3 [AMENDED]

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[OAR Docket #07-572; filed 3-29-07]

**TITLE 165. CORPORATION COMMISSION
CHAPTER 5. RULES OF PRACTICE**

[OAR Docket #07-618]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Fees
Part 1. General Provisions
165:5-3-1. Fees [AMENDED]
Subchapter 7. Commencement of Cause
Part 3. Oil and Gas
165:5-7-9. Well location exception [AMENDED]
Subchapter 15. Orders
165:5-15-6. Location exception orders [AMENDED]

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[OAR Docket #07-618; filed 4-2-07]

Submissions for Review

TITLE 165. CORPORATION COMMISSION CHAPTER 10. OIL AND GAS CONSERVATION

[OAR Docket #07-619]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 10. Oil and Gas Conservation [AMENDED]

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[OAR Docket #07-619; filed 4-2-07]

TITLE 165. CORPORATION COMMISSION CHAPTER 30. MOTOR CARRIERS

[OAR Docket #07-620]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 30. Motor Carriers [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-620; filed 4-2-07]

TITLE 165. CORPORATION COMMISSION CHAPTER 35. ELECTRIC UTILITY RULES

[OAR Docket #07-621]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 34. Competitive Procurement

165:35-34-3. RFP Competitive Bidding Procurement Process [AMENDED]

Subchapter 37. Integrated Resource Planning

165:35-37-4. Integrated Resource Plan Reviews [AMENDED]

Subchapter 39. Minimum Filing Requirements [NEW]

165:35-39-1. Purpose and Scope of this Subchapter [NEW]

165:35-39-2. Definitions and Acronyms [NEW]

165:35-39-3. Confidential Information [NEW]

165:35-39-4. Initiation of Fuel Audit or Prudence Review [NEW]

165:35-39-5. Actual Fuel and Purchased Power Expenses [NEW]

165:35-39-6. Fuel Purchase and Power Procurement Practices [NEW]

165:35-39-7. Fuel, Purchased Power and Fuel-Related Contracts [NEW]

165:35-39-8. Fuel Transportation Agreements [NEW]

165:35-39-9. Disclosure of all Fuel Related and Purchased Power Affiliate Transactions [NEW]

165:35-39-10. Material Public Filings and Disclosures [NEW]

165:35-39-11. Generator Availability and Dispatch [NEW]

165:35-39-12. Eligible Fuel Costs [NEW]

165:35-39-13. Sunset Provisions [NEW]

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TITLE 170. DEPARTMENT OF CORRECTIONS CHAPTER 1. ORGANIZATION

[OAR Docket #07-603]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

170:1-1-2 [AMENDED]

170:1-1-3 [AMENDED]

170:1-1-4 [AMENDED]

170:1-1-6 [AMENDED]

170:1-1-7 [AMENDED]

170:1-1-8 [AMENDED]

170:1-1-9 [AMENDED]

170:1-1-10 [AMENDED]

170:1-1-11 [AMENDED]

170:1-1-12 [AMENDED]

170:1-1-13 [AMENDED]

170:1-1-14 [AMENDED]

170:1-1-15 [AMENDED]

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[OAR Docket #07-603; filed 3-30-07]

**TITLE 170. DEPARTMENT OF
CORRECTIONS
CHAPTER 20. COMMUNITY WORK
CENTERS**

[OAR Docket #07-604]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

170:20-1-3 [AMENDED]

Subchapter 3. Application and Approval

170:20-3-1 [AMENDED]

170:20-3-2 [AMENDED]

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[OAR Docket #07-604; filed 3-30-07]

**TITLE 170. DEPARTMENT OF
CORRECTIONS
CHAPTER 35. EMPLOYEE RECRUITMENT
REFERRAL INCENTIVE PROGRAM**

[OAR Docket #07-605]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

170:35-1-2 [AMENDED]

170:35-1-3 [AMENDED]

170:35-1-4 [AMENDED]

170:35-1-5 [AMENDED]

170:35-1-6 [AMENDED]

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[OAR Docket #07-605; filed 3-30-07]

**TITLE 330. OKLAHOMA HOUSING
FINANCE AGENCY
CHAPTER 36. AFFORDABLE HOUSING
TAX CREDIT PROGRAM**

[OAR Docket #07-597]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 2. Allocation Procedures

330:36-2-12 [AMENDED]

Subchapter 4. Development Applications and Selection

330:36-4-1.1 [AMENDED]

330:36-4-2 [AMENDED]

Subchapter 6. Program Administration

330:36-6-1 [AMENDED]

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[OAR Docket #07-597; filed 3-30-07]

**TITLE 340. DEPARTMENT OF HUMAN
SERVICES
CHAPTER 1. FUNCTION AND STRUCTURE
OF THE DEPARTMENT**

[OAR Docket #07-546]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 11. Civil Rights and Nondiscrimination
on Basis of Race, Color, National Origin, Sex, Age,
Religion, or Disability

Part 2. Food Stamp Program Discrimination Complaint,
and Non-Compliance, and Rude Treatment System

340:1-11-21 through 340:1-11-22 [AMENDED]

(Reference APA WF 07-06)

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[OAR Docket #07-546; filed 3-28-07]

Submissions for Review

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 2. ADMINISTRATIVE COMPONENTS

[OAR Docket #07-547]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 1. Human Resources Management Division (HRMD)

Part 4. Alcohol and Drug Testing ~~Policy~~ Applicable to OKDHS Employees and Applicants

340:2-1-42 through 340:2-1-43 [AMENDED]

340:2-1-45 [REVOKED]

340:2-1-47 [REVOKED]

Subchapter 15. Risk and Safety Management

Part 5. Alcohol and Drug Testing ~~Policy~~ for Drivers of Commercial Vehicles

340:2-15-42 [AMENDED]

(Reference APA WF 06-28)

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[OAR Docket #07-547; filed 3-28-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 2. ADMINISTRATIVE COMPONENTS

[OAR Docket #07-548]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 28. Office of Administrative Hearings: Child Support

340:2-28-1 through 340:2-28-2 [AMENDED]

340:2-28-4.2 through 340:2-28-4.3 [AMENDED]

340:2-28-4.4 [NEW]

340:2-28-16.1 through 340:2-28-16.2 [AMENDED]

340:2-28-17.2 [AMENDED]

340:2-28-19 through 340:2-28-20 [AMENDED]

340:2-28-22 [AMENDED]

340:2-28-24 through 340:2-28-26 [AMENDED]

340:2-28-29 through 340:2-28-31 [AMENDED]

340:2-28-33 [AMENDED]

(Reference APA WF 07-02)

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TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 5. ADULT PROTECTIVE SERVICES

[OAR Docket #07-549]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Investigation of Adult Protective Services

340:5-5-4 [AMENDED]

(Reference APA WF 07-03)

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[OAR Docket #07-549; filed 3-28-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 10. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

[OAR Docket #07-550]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Conditions of Eligibility-Need

Part 3. Income

340:10-3-32 [AMENDED]

(Reference APA WF 07-07)

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[OAR Docket #07-550; filed 3-28-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 40. CHILD CARE SERVICES**

[OAR Docket #07-551]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 7. Eligibility
340:40-7-11 [AMENDED]
(Reference APA WF 07-08)

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[OAR Docket #07-551; filed 3-28-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 50. FOOD STAMP PROGRAM**

[OAR Docket #07-552]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 7. Financial Eligibility Criteria
Part 3. Income
340:50-7-30 [AMENDED]
(Reference APA WF 07-09)

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[OAR Docket #07-552; filed 3-28-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 65. PUBLIC ASSISTANCE PROCEDURES**

[OAR Docket #07-553]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Eligibility for Benefits
340:65-3-1 through 340:65-3-2 [AMENDED]

(Reference APA WF 07-04)
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[OAR Docket #07-553; filed 3-28-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 70. SOCIAL SERVICES**

[OAR Docket #07-554]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 8. Supplemental Security Income-Disabled Children's Program (SSI-DCP)
340:70-8-1 [AMENDED]
Subchapter 9. Health Related Services
340:70-9-1 [REVOKED]
340:70-9-2 [AMENDED]
340:70-9-5 [AMENDED]
340:70-9-7 [REVOKED]
340:70-9-9 [AMENDED]
340:70-9-10 [REVOKED]
340:70-9-15 [REVOKED]
340:70-9-17 [AMENDED]

(Reference APA WF 06-26)

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**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 75. CHILD WELFARE**

[OAR Docket #07-536]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Child Protective Services
340:75-3-8.4 through 340:75-3-8.5 [AMENDED]
Subchapter 4. Family-Centered and Community Services
Part 1. Voluntary Family-Centered Services
340:75-4-14 [AMENDED]

Submissions for Review

Subchapter 13. Other Child Welfare Services and Medical Services for Children in Out-of-Home Care

Part 3. Income and Resources of the Child

340:75-13-28 through 340:75-13-29 [AMENDED]

(Reference APA WF 07-01)

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TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES DIVISION

[OAR Docket #07-555]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Client Services

Part 3. Service Provisions

340:100-5-22 [AMENDED]

340:100-5-25 [REVOKED]

(Reference APA WF 07-05)

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TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 110. LICENSING SERVICES

[OAR Docket #07-537]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Licensing Standards for Child Care Facilities

Part 8. Requirements for Children's Shelters [REVOKED]

340:110-3-130 through 340:110-3-144 [REVOKED]

Part 11. Requirements for Therapeutic Camps [REVOKED]

340:110-3-180 through 340:110-3-195 [REVOKED]

Subchapter 5. Requirements for Child-Placing Agencies

Part 7. Requirements for Group Homes [REVOKED]

340:110-5-80 through 340:110-5-99 [REVOKED]

(Reference APA WF 07-10)

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TITLE 390. COUNCIL ON LAW ENFORCEMENT EDUCATION AND TRAINING
CHAPTER 10. PEACE OFFICER CERTIFICATION

[OAR Docket #07-541]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

390:10-1-2 [AMENDED]

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[OAR Docket #07-541; filed 3-28-07]

TITLE 390. COUNCIL ON LAW ENFORCEMENT EDUCATION AND TRAINING
CHAPTER 15. BASIC PEACE OFFICER CERTIFICATION TRAINING

[OAR Docket #07-542]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. Basic Academy Programs

390:15-1-12 [AMENDED]

390:15-1-13 [AMENDED]

390:15-1-15 [AMENDED]

390:15-1-18 [AMENDED]

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[OAR Docket #07-542; filed 3-28-07]

**TITLE 390. COUNCIL ON LAW
ENFORCEMENT EDUCATION AND
TRAINING
CHAPTER 27. POLICE OFFICER ANNUAL
FIREARMS REQUALIFICATION**

[OAR Docket #07-543]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 27. Police Officer Annual Firearms
Requalification [NEW]

SUBMITTED TO GOVERNOR:

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[OAR Docket #07-543; filed 3-28-07]

**TITLE 390. COUNCIL ON LAW
ENFORCEMENT EDUCATION AND
TRAINING
CHAPTER 35. REGULATION OF PRIVATE
SECURITY INDUSTRY**

[OAR Docket #07-544]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. License Requirements
390:35-5-2 [AMENDED]
390:35-5-9 [AMENDED]
Subchapter 15. Training Standards and Requirements
390:35-15-2 [AMENDED]

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**TITLE 390. COUNCIL ON LAW
ENFORCEMENT EDUCATION AND
TRAINING
CHAPTER 55. FACILITIES MANAGEMENT**

[OAR Docket #07-545]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 55. Facilities Management [NEW]

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[OAR Docket #07-545; filed 3-28-07]

**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 10. PHYSICIANS AND
SURGEONS**

[OAR Docket #07-574]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. General Provisions
435:10-1-4. Definitions [AMENDED]

SUBMITTED TO GOVERNOR:

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**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 10. PHYSICIANS AND
SURGEONS**

[OAR Docket #07-575]

RULEMAKING ACTION:

Statement of submission for gubernatorial and legislative review.

RULES:

Subchapter 4. Application and Examination Procedures for
Licensure as Physician and Surgeon
435:10-4-6. Medical licensure examination [AMENDED]

Submissions for Review

435:10-4-7. Licensure by endorsement [AMENDED]

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**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 10. PHYSICIANS AND
SURGEONS**

[OAR Docket #07-576]

RULEMAKING ACTION:

Statement of submission for gubernatorial and legislative review.

RULES:

Subchapter 21. Abortions [NEW]

435:10-21-1. Informed Consent [NEW]

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**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 20. PHYSICAL THERAPISTS
AND ASSISTANTS**

[OAR Docket #07-577]

RULEMAKING ACTION:

Statement of submission for gubernatorial and legislative review.

RULES:

Subchapter 3. Licensure of Physical Therapists and Assistants

435:20-3-1.1. Training outside the U.S. [AMENDED]

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**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 40. REGISTERED
ELECTROLOGISTS**

[OAR Docket #07-578]

RULEMAKING ACTION:

Statement of submission for gubernatorial and legislative review.

RULES:

435:40-1-6. Curriculum of study and internship requirements [AMENDED]

435:40-1-7. Application procedures [AMENDED]

435:40-1-9. License renewal and replacement [AMENDED]

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**TITLE 435. STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
CHAPTER 55. LICENSED ORTHOTISTS
AND PROSTHETISTS AND REGISTERED
TECHNICIANS AND ASSISTANTS**

[OAR Docket #07-579]

RULEMAKING ACTION:

Statement of submission for gubernatorial and legislative review.

RULES:

Subchapter 5. Annual Renewal/Continuing Education

435:55-5-2. Requirements for renewal of license or registration [AMENDED]

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[OAR Docket #07-579; filed 3-29-07]

**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 1. ADMINISTRATIVE
OPERATIONS**

[OAR Docket #07-526]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Open Records Act
475:1-3-1 [AMENDED]
Subchapter 5. Administrative Actions
475:1-5-6 [AMENDED]
475:1-5-7 [AMENDED]
475:1-5-11 [NEW]

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**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 10. REQUIREMENTS FOR
REGISTRATION**

[OAR Docket #07-527]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

475:10-1-10 [AMENDED]
475:10-1-17 [AMENDED]

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[OAR Docket #07-527; filed 3-27-07]

**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 20. SECURITY REQUIREMENTS**

[OAR Docket #07-528]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

475:20-1-5 [AMENDED]

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[OAR Docket #07-528; filed 3-27-07]

**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 25. RECORDS AND REPORTS OF
REGISTRANTS**

[OAR Docket #07-529]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

475:25-1-3 [AMENDED]
475:25-1-4 [AMENDED]
475:25-1-6 [REVOKED]
475:25-1-11 [AMENDED]
475:25-1-13 [AMENDED]

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[OAR Docket #07-529; filed 3-27-07]

**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 30. LABELING REQUIREMENTS**

[OAR Docket #07-530]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

Submissions for Review

RULES:

475:30-1-2 [AMENDED]
475:30-1-3 [AMENDED]
475:30-1-4 [AMENDED]
475:30-1-7 [AMENDED]
475:30-1-9 [REVOKED]
475:30-1-14 [AMENDED]
475:30-1-15 [AMENDED]

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[OAR Docket #07-530; filed 3-27-07]

**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 35. TRANSFER AND DISPOSAL
OF CONTROLLED DANGEROUS DRUGS**

[OAR Docket #07-531]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

475:35-1-3 [AMENDED]
475:35-1-5 [REVOKED]

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[OAR Docket #07-531; filed 3-27-07]

**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 40. ENFORCEMENT AND
ADMINISTRATIVE INSPECTIONS**

[OAR Docket #07-532]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

475:40-1-2 [AMENDED]

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**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 45. OKLAHOMA SCHEDULE
TWO ABUSE REDUCTION (OSTAR)
REPORTING REQUIREMENTS**

[OAR Docket #07-533]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

475:45-1-1 [AMENDED]
475:45-1-2 [AMENDED]
475:45-1-3 [AMENDED]
475:45-1-4 [AMENDED]
475:45-1-5 [AMENDED]
475:45-1-6 [AMENDED]

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[OAR Docket #07-533; filed 3-27-07]

**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 50. ANIMAL CONTROL
OFFICERS**

[OAR Docket #07-534]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

475:50-1-1. Purpose [NEW]
475:50-1-2. Qualifications for registration/required training [NEW]
475:50-1-3. Exempt from fees [NEW]
475:50-1-4. Special conditions on ordering controlled substances [NEW]
475:50-1-5. Special conditions for animal control officers storing controlled dangerous substances [NEW]
475:50-1-6. Special conditions for animal control officers transporting controlled dangerous substances [NEW]
475:50-1-7. Readily available records for animal control officers [NEW]

475:50-1-8. Inspections [NEW]
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[OAR Docket #07-534; filed 3-27-07]

**TITLE 475. OKLAHOMA STATE BUREAU
OF NARCOTICS AND DANGEROUS DRUGS
CONTROL
CHAPTER 55. PSEUDOEPHEDRINE
CONTROL**

[OAR Docket #07-535]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
475:55-1-5 [NEW]
475:55-1-7 [AMENDED]
475:55-1-8 [REVOKED]
475:55-1-9 [AMENDED]
475:55-1-10 [AMENDED]
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[OAR Docket #07-535; filed 3-27-07]

**TITLE 530. OFFICE OF PERSONNEL
MANAGEMENT
CHAPTER 10. MERIT SYSTEM OF
PERSONNEL ADMINISTRATION RULES**

[OAR Docket #07-538]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
PROPOSED RULES:
Appendix A. Pay Band Schedule [REVOKED]
Appendix A. Pay Band Schedule [NEW]
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[OAR Docket #07-538; filed 3-27-07]

**TITLE 535. OKLAHOMA STATE BOARD OF
PHARMACY
CHAPTER 1. ADMINISTRATIVE
OPERATIONS**

[OAR Docket #07-586]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 5. General Course in Method of Operation
535:1-5-5.1. Complaint confidentiality [AMENDED]
Subchapter 7. Individual Proceedings
535:1-7-4. Failure to appear and/or failure to comply
[AMENDED]
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[OAR Docket #07-586; filed 3-29-07]

**TITLE 535. OKLAHOMA STATE BOARD OF
PHARMACY
CHAPTER 10. PHARMACISTS; INTERNS,
PRECEPTORS AND TRAINING AREAS**

[OAR Docket #07-587]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 5. Interns, Preceptors and Training Areas
535:10-5-4. Intern Practice requirements [AMENDED]
Subchapter 7. Pharmacist Licensure
535:10-7-6. Reciprocity licensure applicants [AMENDED]
535:10-7-8. Foreign pharmacy graduates licensure
applicants [AMENDED]
Subchapter 11. Pharmacist Administration of
Immunizations
535:10-11-3. D.Ph. administering of immunization
requirements [AMENDED]
535:10-11-4. Immunization registration of ~~D.Ph.~~
[AMENDED]
535:10-11-5. D.Ph. training requirements for
administration of immunizations [AMENDED]
535:10-11-6. Records [AMENDED]

Submissions for Review

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[OAR Docket #07-587; filed 3-29-07]

**TITLE 535. OKLAHOMA STATE BOARD OF
PHARMACY
CHAPTER 13. EMERGENCY / DISASTER
PHARMACY RESPONSE**

[OAR Docket #07-588]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

535:13-1-1. Purpose [NEW]

535:13-1-2. Reserved [NEW]

535:13-1-3. Declaration of Emergency [NEW]

535:13-1-4. Pharmacy Emergency / Disaster Response
[NEW]

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[OAR Docket #07-588; filed 3-29-07]

**TITLE 535. OKLAHOMA STATE BOARD OF
PHARMACY
CHAPTER 15. PHARMACIES**

[OAR Docket #07-589]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Pharmacies

535:15-3-2. Pharmacy responsibilities [AMENDED]

535:15-3-4.1. Pharmacy licensing requirement
[AMENDED]

535:15-3-6. Required library reference books or computer
sources [AMENDED]

535:15-3-12. Transfer of prescription refill information
[AMENDED]

535:15-3-18. Pharmacy prescription drug purchases
records [NEW]

535:15-3-21. Prescription fill, refill and partial fill records
and reports [AMENDED]

Subchapter 5. Hospital Pharmacies

535:15-5-7.6. Pharmacy technician annual permit
requirement [AMENDED]

Subchapter 6. Hospital Drug Room Rules

535:15-6-9. Emergency room pre-packaged medications
formulary [AMENDED]

Subchapter 13. Pharmacy Technicians and Supportive
Personnel

535:15-13-5. Supervision of pharmacy technicians
[AMENDED]

535:15-13-8. Technician annual permit requirement
[AMENDED]

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**TITLE 535. OKLAHOMA STATE BOARD OF
PHARMACY
CHAPTER 15. PHARMACIES**

[OAR Docket #07-590]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 17. Nuclear Pharmacy

535:15-17-3. Definitions [AMENDED]

535:15-17-5. General requirements [AMENDED]

535:15-17-7. Minimum Equipment [AMENDED]

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**TITLE 535. OKLAHOMA STATE BOARD OF
PHARMACY
CHAPTER 25. RULES AFFECTING
VARIOUS REGISTRANTS**

[OAR Docket #07-591]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Applicants, Registrants, and Applications

535:25-3-3. Qualifications and requirements for registrant
applicants [AMENDED]

535:25-3-7. Change requirements and notification [AMENDED]
Subchapter 5. General Requirements or Procedures
535:25-5-5. Prescription drug (Rx Only) purchase and record requirements [NEW]

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**TITLE 575. STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS
CHAPTER 10. LICENSURE OF PSYCHOLOGISTS**

[OAR Docket #07-592]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- 575:10-1-3 [AMENDED]
- 575:10-1-8 [AMENDED]
- 575:10-1-10 [AMENDED]

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**TITLE 580. DEPARTMENT OF CENTRAL SERVICES
CHAPTER 10. FACILITIES MANAGEMENT**

[OAR Docket #07-657]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 2. General Provisions [AMENDED]
580:10-2-1 [AMENDED]
580:10-2-2 [AMENDED]
Subchapter 5. use of Public Areas of Capitol and Plazas [AMENDED]
580:10-5-6 [AMENDED]
Subchapter 7. Use of State Capitol Park [AMENDED]
580:10-7-3 [AMENDED]
Subchapter 9. Operation of Buildings Owned, Used or Occupied by or on Behalf of the State [AMENDED]

- Part 1. Smoking [AMENDED]
580:10-9-3 [AMENDED]
Part 4. Access to the J. Howard Edmondson and Robert S. Kerr Office Buildings [AMENDED]
580:10-9-16 [AMENDED]
Part 5. General Operations of public Buildings Managed by the Department of Central Services [AMENDED]
580:10-9-21 [AMENDED]
580:10-9-24 [NEW]

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**TITLE 580. DEPARTMENT OF CENTRAL SERVICES
CHAPTER 15. CENTRAL PURCHASING**

[OAR Docket #07-658]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 2. General Provisions [AMENDED]
80:15-2-1 [AMENDED]
580:15-2-2 [AMENDED]
580:15-2-6 [AMENDED]
580:15-2-7 [AMENDED]
Subchapter 4. Supplier Provisions [AMENDED]
580:15-4-2 [AMENDED]
580:15-4-4 [AMENDED]
580:15-4-5 [AMENDED]
580:15-4-6 [AMENDED]
580:15-4-7 [AMENDED]
580:15-4-8 [AMENDED]
580:15-4-10 [AMENDED]
580:15-4-11 [AMENDED]
580:15-4-12 [AMENDED]
580:15-4-13 [AMENDED]
580:15-4-14 [AMENDED]
580:15-4-16 [AMENDED]
580:15-4-17 [AMENDED]
580:15-4-18 [AMENDED]
580:15-4-19 [AMENDED]
580:15-4-20. [REVOKED]
Subchapter 6. State Agency Provisions. [AMENDED]
580:15-6-2 [AMENDED]
580:15-6-4 [AMENDED]
580:15-6-5 [AMENDED]
580:15-6-6 [AMENDED]
580:15-6-7 [AMENDED]

Submissions for Review

580:15-6-8 [REVOKED]
580:15-6-9 [REVOKED]
580:15-6-10 [AMENDED]
580:15-6-11 [REVOKED]
580:15-6-13 [REVOKED]
580:15-6-14 [AMENDED]
580:15-6-15 [AMENDED]
580:15-6-21 [AMENDED]
580:15-6-22 [REVOKED]
580:15-6-23 [REVOKED]
580:15-6-24 [REVOKED]

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**TITLE 580. DEPARTMENT OF CENTRAL
SERVICES
CHAPTER 20. CONSTRUCTION AND
PROPERTIES**

[OAR Docket #07-660]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. Construction Contracting
580:20-1-1 [AMENDED]
580:20-1-2 [AMENDED]
580:20-1-3 [AMENDED]
580:20-1-6 [AMENDED]
580:20-1-8.1 [AMENDED]
580:20-1-8.2 [AMENDED]
580:20-1-10 [AMENDED]
580:20-1-10.1 [NEW]
580:20-1-13 [AMENDED]
580:20-1-14 [AMENDED]
580:20-1-19 [AMENDED]
580:20-1-21 [REVOKED]
580:20-1-22 [AMENDED]
580:20-1-23 [AMENDED]
580:20-1-24 [NEW]
Subchapter 3. Selection of Architects, Engineers, and Other
Design Consultants. [AMENDED]
580:20-3-1 [AMENDED]
580:20-3-2 [AMENDED]
580:20-3-3 [AMENDED]
580:20-3-4 [AMENDED]
580:20-3-5 [AMENDED]

580:20-3-6 [AMENDED]
580:20-3-7 [AMENDED]
580:20-3-8 [NEW]
Subchapter 5. Minimum Codes for State Construction.
[AMENDED]
580:20-5-2 [AMENDED]
580:20-5-3 [AMENDED]
580:20-5-4 [AMENDED]
580:20-5-6 [AMENDED]
Subchapter 7. Procedures for Agencies to Perform
Responsibilities Exercised by the Construction and
Properties Division. [AMENDED]
580:20-7-2 [AMENDED]
580:20-7-7 [NEW]
Subchapter 9. Full-time Employment by Agencies for
Minor Construction Projects. [AMENDED]
580:20-9-2 [AMENDED]
Subchapter 15. Energy Services Contracts. [AMENDED]
580:20-15-2 [AMENDED]
580:20-15-13 [NEW]
Subchapter 17. Construction Management Procedures and
Requirements. [AMENDED]
580:20-17-2 [AMENDED]
580:20-17-3 [AMENDED]
580:20-17-4 [AMENDED]
580:20-17-5 [AMENDED]
580:20-17-9 [AMENDED]
580:20-17-10 [NEW]
Subchapter 19. Design-Build Procedures and
Requirements. [AMENDED]
580:20-19-2 [AMENDED]
580:20-19-14 [NEW]
Subchapter 21. Selection of Construction Management and
Design-Build Firms. [AMENDED]
580:20-21-2 [AMENDED]
580:20-21-3 [AMENDED]
580:20-21-9 [NEW]
Subchapter 23. Fees for Services. [AMENDED]
580:20-23-1 [AMENDED]
580:20-23-2 [AMENDED]
580:20-23-4 [NEW]
Subchapter 25. Pre-Construction Planning. [NEW]
580:20-25-1 through 580:20-25-7 [NEW]

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[OAR Docket #07-660; filed 4-4-07]

**TITLE 580. DEPARTMENT OF CENTRAL SERVICES
CHAPTER 45. PLAN OF OPERATION FOR OKLAHOMA STATE AGENCY FOR SURPLUS PROPERTY**

[OAR Docket #07-659]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

580:45-1-10 [REVOKED]

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[OAR Docket #07-659; filed 4-4-07]

**TITLE 660. DEPARTMENT OF SECURITIES
CHAPTER 2. ORGANIZATION AND PROCEDURES OF DEPARTMENT OF SECURITIES**

[OAR Docket #07-585]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 9. Individual Proceeding Practices and Procedures

660:2-9-1 [AMENDED]

660:2-9-2 [AMENDED]

660:2-9-3 [AMENDED]

660:2-9-4 [AMENDED]

660:2-9-6. [AMENDED]

660:2-9-7 [AMENDED]

660:2-9-8 [AMENDED]

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[OAR Docket #07-585; filed 3-29-07]

**TITLE 660. DEPARTMENT OF SECURITIES
CHAPTER 11. OKLAHOMA UNIFORM SECURITIES ACT OF 2004**

[OAR Docket #07-584]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 7. Investment advisers and investment adviser representatives

660:11-7-41 [AMENDED]

660:11-7-48 [NEW]

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[OAR Docket #07-584; filed 3-29-07]

**TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 45. GROSS PRODUCTION**

[OAR Docket #07-573]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 9. Exemptions and Exclusions

Part 5. Horizontally Drilled Production Wells

710:45-9-21 [AMENDED]

710:45-9-24 [AMENDED]

Part 7. Incremental Production from Enhanced Recovery Projects or Properties

710:45-9-31 [AMENDED]

710:45-9-32 [AMENDED]

710:45-9-32.1 [AMENDED]

710:45-9-34 [AMENDED]

710:45-9-35 [AMENDED]

Part 9. Production Enhancement Projects

710:45-9-40 [AMENDED]

710:45-9-41 [AMENDED]

Part 11. Reestablishment of Production from an Inactive Well

710:45-9-51 [AMENDED]

Part 13. Deep Wells

710:45-9-60 [AMENDED]

Part 15. New Discovery Wells

710:45-9-70 [AMENDED]

710:45-9-71 [AMENDED]

710:45-9-73 [AMENDED]

Part 19. Production Using Three Dimensional Seismic Shoots

Submissions for Review

710:45-9-90 [AMENDED]
710:45-9-92 [AMENDED]
710:45-9-93 [AMENDED]

SUBMITTED TO GOVERNOR:

March 29, 2007

SUBMITTED TO HOUSE:

March 29, 2007

SUBMITTED TO SENATE:

March 29, 2007

[OAR Docket #07-573; filed 3-29-07]

**TITLE 735. STATE TREASURER
CHAPTER 15. RECORDING AND
AUDITING INVESTMENT TRANSACTIONS**

[OAR Docket #07-717]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. Auditing Investment Transactions
735:15-5-1. Duties of OST's Internal Auditor
[AMENDED]

SUBMITTED TO GOVERNOR:

March 23, 2007

SUBMITTED TO HOUSE:

March 23, 2007

SUBMITTED TO SENATE:

March 23, 2007

[OAR Docket #07-717; filed 4-6-07]

**TITLE 735. STATE TREASURER
CHAPTER 80. UNCLAIMED PROPERTY**

[OAR Docket #07-718]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Reporting Requirements
Part 5. Business associations
735:80-3-15. Business associations; reporting
requirements [AMENDED]
Subchapter 7. Claims Process
735:80-7-3. Release of non-cash items [AMENDED]

SUBMITTED TO GOVERNOR:

March 23, 2007

SUBMITTED TO HOUSE:

March 23, 2007

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March 23, 2007

[OAR Docket #07-718; filed 4-6-07]

**TITLE 780. OKLAHOMA DEPARTMENT OF
CAREER AND TECHNOLOGY EDUCATION
CHAPTER 1. GENERAL**

[OAR Docket #07-593]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 17. Travel
780:1-17-1 [AMENDED]

SUBMITTED TO GOVERNOR:

March 30, 2007

SUBMITTED TO HOUSE:

March 30, 2007

SUBMITTED TO SENATE:

March 30, 2007

[OAR Docket #07-593; filed 3-30-07]

**TITLE 780. OKLAHOMA DEPARTMENT OF
CAREER AND TECHNOLOGY EDUCATION
CHAPTER 10. ADMINISTRATION AND
SUPERVISION**

[OAR Docket #07-594]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. State Technical Assistance, Supervision, and
Services
780:10-3-4 [AMENDED]
780:10-3-11 [AMENDED]
Subchapter 5. Finance
780:10-5-4 [AMENDED]
Subchapter 7. Local Programs: Application; Student
Accounting; Evaluation
780:10-7-3 [AMENDED]
Subchapter 9. Service Contracts and Equipment Guidelines
780:10-9-2 [AMENDED]

SUBMITTED TO GOVERNOR:

March 30, 2007

SUBMITTED TO HOUSE:

March 30, 2007

SUBMITTED TO SENATE:

March 30, 2007

[OAR Docket #07-594; filed 3-30-07]

**TITLE 780. OKLAHOMA DEPARTMENT OF
CAREER AND TECHNOLOGY EDUCATION
CHAPTER 15. TECHNOLOGY CENTERS**

[OAR Docket #07-595]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Technology Centers Education

780:15-3-2 [AMENDED]

780:15-3-6 [AMENDED]

780:15-3-7 [AMENDED]

SUBMITTED TO GOVERNOR:

March 30, 2007

SUBMITTED TO HOUSE:

March 30, 2007

SUBMITTED TO SENATE:

March 30, 2007

[OAR Docket #07-595; filed 3-30-07]

**TITLE 780. OKLAHOMA DEPARTMENT OF
CAREER AND TECHNOLOGY EDUCATION
CHAPTER 20. PROGRAMS AND SERVICES**

[OAR Docket #07-596]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Secondary, Full-Time and Short-Term Adult
CareerTech Programs

780:20-3-2 [AMENDED]

Subchapter 5. Programs, Services, and Activities Funded
Through P.L. 105-332 Carl D. Perkins Vocational and
Technical Education Act of 1998

780:20-5-1 [AMENDED]

SUBMITTED TO GOVERNOR:

March 30, 2007

SUBMITTED TO HOUSE:

March 30, 2007

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March 30, 2007

[OAR Docket #07-596; filed 3-30-07]

Gubernatorial Approvals

Upon notification of approval by the Governor of an agency's proposed PERMANENT rulemaking action, the agency must submit a notice of such gubernatorial approval for publication in the *Register*.
For additional information on gubernatorial approvals, see 75 O.S., Section 303.2.

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 15. ANIMAL INDUSTRY

[OAR Docket #07-608]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 44. Farmed Cervidae [NEW]
35:15-44-1 through 35:15-44-19 [NEW]
35:15-44-20 [RESERVED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-608; filed 3-30-07]

TITLE 55. BOARD OF GOVERNORS OF THE LICENSED ARCHITECTS, LANDSCAPE ARCHITECTS AND INTERIOR DESIGNERS OF OKLAHOMA CHAPTER 10. LICENSURE AND PRACTICE OF ARCHITECTS, AND LANDSCAPE ARCHITECTS AND REGISTRATION OF INTERIOR DESIGNERS

[OAR Docket #07-715]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions [AMENDED]
Subchapter 3. Administrative Operations [AMENDED]
Subchapter 5. Application and Eligibility for Licensing or Registration [AMENDED]
Subchapter 7. Examination [AMENDED]
Subchapter 9. Licensing and Registration [AMENDED]
Subchapter 11. Rules of Professional Conduct [AMENDED]
Subchapter 13. Organizational Practice [AMENDED]
Subchapter 15. Violations [AMENDED]
Subchapter 17. Continuing Education Requirements [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-715; filed 4-6-07]

TITLE 245. STATE BOARD OF LICENSURE FOR PROFESSIONAL ENGINEERS AND LAND SURVEYORS CHAPTER 15. LICENSURE AND PRACTICE OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS

[OAR Docket #07-606]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 13. Minimum Standards For Land Surveying
245:15-13-1 [AMENDED]
245:15-13-2 [AMENDED]
Subchapter 17. Licensee's Seal
245:15-17-2 [AMENDED]

GUBERNATORIAL APPROVAL:

March 2, 2007

[OAR Docket #07-606; filed 3-30-07]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 4. RULES OF PRACTICE AND PROCEDURE

[OAR Docket #07-720]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 17. Electronic Reporting [NEW]
252:4-17-1. Purpose, authority and applicability [NEW]
252:4-17-2. Definitions [NEW]
252:4-17-3. Use of electronic document receiving system [NEW]
252:4-17-4. Electronic signature agreement [NEW]
252:4-17-5. Valid electronic signature [NEW]
252:4-17-6. Effect of electronic signature [NEW]
252:4-17-7. Enforcement [NEW]
Appendix E. Electronic Signature Agreement [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-720; filed 4-6-07]

Gubernatorial Approvals

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 210. HIGHWAY SPILL REMEDICATION

[OAR Docket #07-721]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- 252:210-1-1. Purpose, authority and applicability [NEW]
- 252:210-1-2. Definitions [NEW]
- 252:210-1-3. General provisions [NEW]
- 252:210-1-4. Prerequisites for new licenses and renewal [NEW]
- 252:210-1-5. Licensure requirements [NEW]
- 252:210-1-6. Licensee's duties; record keeping [NEW]
- 252:210-1-7. License suspension and revocation [NEW]
- 252:210-1-8. Fees [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-721; filed 4-6-07]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 300. LABORATORY ACCREDITATION

[OAR Docket #07-722]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 19. Classifications
- 252:300-19-4 [NEW]
- Subchapter 21. Categories
- 252:300-21-1 [AMENDED]
- 252:300-21-2 [AMENDED]
- Appendix B.1. Additional Analytes [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-722; filed 4-6-07]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 410. RADIATION MANAGEMENT

[OAR Docket #07-723]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 5. Certification of Industrial Radiographers
- 252:410-5-3 [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-723; filed 4-6-07]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 410. RADIATION MANAGEMENT

[OAR Docket #07-724]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 10. Radioactive Materials Program
- Part 101. Radioactive Materials Program Fees
- 252:410-10-118 [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-724; filed 4-6-07]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 606. OKLAHOMA POLLUTANT DISCHARGE ELIMINATION SYSTEM (OPDES) STANDARDS

[OAR Docket #07-725]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. Introduction
- 252:606-1-3 [AMENDED]
- 252:606-1-4 [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-725; filed 4-6-07]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 611. GENERAL WATER QUALITY

[OAR Docket #07-726]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions
252:611-1-3 [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-726; filed 4-6-07]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 616. INDUSTRIAL WASTEWATER SYSTEMS**

[OAR Docket #07-727]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. Permit Procedures
252:616-3-4 [AMENDED]
Subchapter 11. Land Application Standards
252:616-11-1 [AMENDED]
252:616-11-5 [AMENDED]
252:616-11-7 [NEW]
252:616-11-8 [NEW]
Subchapter 13. Closure Standards
252:616-13-3 [AMENDED]
Appendix D. Class III Impoundment Design [NEW]
Appendix E. Class III Impoundment Closure [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-727; filed 4-6-07]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 623. PRETREATMENT FOR CENTRAL TREATMENT TRUSTS**

[OAR Docket #07-728]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions
252:623-1-3 [AMENDED]
252:623-1-4 [AMENDED]
252:623-1-7 [AMENDED]
Subchapter 5. Pretreatment of Wastewater
252:623-5-3 [AMENDED]
Subchapter 7. Wastewater Discharge Permit Application
252:623-7-4 [AMENDED]
Subchapter 9. Permit Issuance Process
252:623-9-2 [AMENDED]
Subchapter 11. Reporting Requirements

252:623-11-7 [AMENDED]
Subchapter 15. Confidential Information
252:623-15-1 [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-728; filed 4-6-07]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 626. PUBLIC WATER SUPPLY CONSTRUCTION STANDARDS**

[OAR Docket #07-729]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. Permit Procedures
252:626-3-10 [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-729; filed 4-6-07]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 631. PUBLIC WATER SUPPLY OPERATION**

[OAR Docket #07-730]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Introduction
252:631-1-3 [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-730; filed 4-6-07]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 690. WATER QUALITY STANDARDS IMPLEMENTATION**

[OAR Docket #07-731]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Introduction
252:690-1-2 [AMENDED]
252:690-1-3 [AMENDED]

252:690-1-4 [AMENDED]
Subchapter 3. Point Source Discharges

252:690-3-2 [AMENDED]

252:690-3-3 [AMENDED]

252:690-3-10 [AMENDED]

252:690-3-14 [AMENDED]

252:690-3-19 [AMENDED]

252:690-3-26 [AMENDED]

252:690-3-29 [AMENDED]

252:690-3-31 [AMENDED]

252:690-3-32 [AMENDED]

252:690-3-41 [AMENDED]

252:690-3-42 [AMENDED]

252:690-3-91 [AMENDED]

Appendix I. Performance-Based Effluent Monitoring
Frequency Reductions. [REVOKED]

Appendix I. Performance-Based Effluent Monitoring
Frequency Reductions. [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-731; filed 4-6-07]

**TITLE 252. DEPARTMENT OF
ENVIRONMENTAL QUALITY
CHAPTER 710. WATERWORKS AND
WASTEWATER WORKS OPERATOR
CERTIFICATION**

[OAR Docket #07-732]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

252:710-1-4 [AMENDED]

Subchapter 7. Shared Operators For Small Systems [NEW]

252:710-7-1 [NEW]

252:710-7-2 [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-732; filed 4-6-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES
AND PROCESS**

[OAR Docket #07-680]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

317:2-1-2 [AMENDED]

317:2-1-5 [AMENDED]

(Reference APA WF # 06-34)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-680; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 10. PURCHASING**

[OAR Docket #07-661]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

317:10-1-1 through 317:10-1-5 [AMENDED]

317:10-1-7 [AMENDED]

317:10-1-9 through 317:10-1-12 [AMENDED]

317:10-1-15 through 317:10-1-20 [AMENDED]

(Reference APA WF # 06-04)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-661; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 25. SOONERCARE CHOICE**

[OAR Docket #07-672]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 7. SoonerCare Choice

Part 3. Enrollment Criteria

317:25-7-13 [AMENDED]

(Reference APA WF # 06-19)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-672; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-663]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Individual Providers and Specialties

Part 77. Speech and Hearing Services
317:30-5-676 [AMENDED]
(Reference APA WF # 06-06)
GUBERNATORIAL APPROVAL:
March 15, 2007

[OAR Docket #07-663; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-664]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 3. General Provider Policies
- Part 3. General Medical Program Information
317:30-3-40 [AMENDED]
- Subchapter 5. Individual Providers and Specialties
- Part 41. Family Support Services
317:30-5-410 through 317:30-5-412 [AMENDED]
- Part 51. Habilitation Services
317:30-5-480 through 317:30-5-482 [AMENDED]
- (Reference APA WF # 06-07 and 06-48A)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-664; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-666]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 85. ADvantage Program Waiver Services
317:30-5-763 through 317:30-5-764 [AMENDED]
- Part 95. Agency Personal Care Services
317:30-5-951 through 30-5-953 [AMENDED]
- (Reference APA WF # 06-13A)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-666; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-668]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 39. Skilled and Registered Nursing Services
317:30-5-391 through 317:30-5-393 [AMENDED]
- (Reference APA WF # 06-14)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-668; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-669]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 1. Physicians
317:30-5-13 [AMENDED]
- Part 5. Pharmacists
317:30-5-70.2 [AMENDED]
- (Reference APA WF # 06-16 and 06-03)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-669; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-670]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 3. General Provider Policies
- Part 4. Early and Periodic Screening, Diagnosis and
Treatment (EPSDT) Program/Child Health Services
317:30-3-65.4 [AMENDED]
- Subchapter 5. Individual Providers and Specialties

Gubernatorial Approvals

Part 1. Physicians

317:30-5-25 [AMENDED]

(Reference APA WF # 06-17 and 06-09)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-670; filed 4-4-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-674]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Individual Providers and Specialties

Part 62. Private Duty Nursing

317:30-5-556 [AMENDED]

317:30-5-558 [AMENDED]

317:30-5-560 [AMENDED]

317:30-5-560.1 [AMENDED]

317:30-5-560.2 [AMENDED]

(Reference APA WF# 06-25 and 06-26)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-674; filed 4-4-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-675]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Individual Providers and Specialties

Part 61. Home Health Agencies

317:30-5-545 [AMENDED]

(Reference APA WF # 06-27)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-675; filed 4-4-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-676]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-12 [AMENDED]

317:30-5-22 [AMENDED]

317:30-5-24 [AMENDED]

Part 19. Nurse Midwives

317:30-5-226 [AMENDED]

Part 35. Rural Health Clinics

317:30-5-355.1 [AMENDED]

317:30-5-361 [AMENDED]

Part 49. Family Planning Centers

317:30-5-466 [AMENDED]

317:30-5-467 [AMENDED]

Part 89. Radiological Mammographer

317:30-5-901 [AMENDED]

(Reference APA WF # 06-28 and 06-22)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-676; filed 4-4-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-677]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. General Provider Policies

Part 3. General Medical Program Information

317:30-3-59 [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 10. Bariatric Surgery [NEW]

317:30-5-137 through 317:30-5-141 [NEW]

(Reference APA WF # 06-29)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-677; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-678]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 5. Individual Providers and Specialities
- Part 33. Transportation by Ambulance
- 317:30-5-335 [AMENDED]
- 317:30-5-335.1 [NEW]
- 317:30-5-336 [AMENDED]
- 317:30-5-336.1 through 317:30-5-336.13 [NEW]
- 317:30-5-337 [AMENDED]
- 317:30-5-339 [AMENDED]
- (Reference APA WF # 06-32)**

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-678; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-679]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 5. Individual Providers and Specialities
- Part 3. Hospitals
- 317:30-5-40 [AMENDED]
- 317:30-5-40.1 [NEW]
- 317:30-5-40.2 [NEW]
- 317:30-5-41 [AMENDED]
- 317:30-5-41.1 [NEW]
- 317:30-5-42 [REVOKED]
- 317:30-5-42.1 through 317:30-5-42.18 [NEW]
- 317:30-5-47 [AMENDED]
- 317:30-5-47.1 through 317:30-5-47.4 [AMENDED]
- 317:30-5-50 [AMENDED]
- 317:30-5-56 through 317:30-5-57 [NEW]
- Part 63. Ambulatory Surgical Centers
- 317:30-5-566 [AMENDED]
- 317:30-5-567 [AMENDED]
- (Reference APA WF # 06-33)**

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-679; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-681]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 5. Individual Providers and Specialities
- Part 1. Physicians
- 317:30-5-14 [AMENDED]
- (Reference APA WF # 06-38)**

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-681; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR
ADULTS AND CHILDREN-ELIGIBILITY**

[OAR Docket #07-667]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 15. Personal Care Services
- 317:35-15-2 [AMENDED]
- 317:35-15-8 through 317:35-15-8.1 [AMENDED]
- 317:35-15-10 [AMENDED]
- 317:35-15-13.1 [AMENDED]
- (Reference APA WF # 06-13B)**

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-667; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR
ADULTS AND CHILDREN-ELIGIBILITY**

[OAR Docket #07-671]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 3. Coverage and Exclusions
- 317:35-3-2 [AMENDED]
- (Reference APA WF # 06-18)**

Gubernatorial Approvals

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-671; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR
ADULTS AND CHILDREN-ELIGIBILITY**

[OAR Docket #07-673]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 21. Breast and Cervical Cancer Treatment
Program

317:35-21-12 [AMENDED]

(Reference APA WF # 06-21)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-673; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 40. DEVELOPMENTAL
DISABILITIES SERVICES**

[OAR Docket #07-662]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Client Services
Part 5. Specialized Foster Care

317:40-5-55 [AMENDED]

Part 9. Service Provisions

317:40-5-103 [AMENDED]

(Reference APA WF # 06-05)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-662; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 40. DEVELOPMENTAL
DISABILITIES SERVICES**

[OAR Docket #07-682]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Client Services

Part 1. ~~Companion/Adult Foster Care Services by Agency~~
Companion Services

317:40-5-3 [AMENDED]

Part 11. Community Residential Supports

317:40-5-152 [AMENDED]

Subchapter 7. Waiver Employment Services

317:40-7-8 [AMENDED]

317:40-7-18 [AMENDED]

(Reference APA WF # 06-48B)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-682; filed 4-4-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 45. OKLAHOMA EMPLOYER
AND EMPLOYEE PARTNERSHIP FOR
INSURANCE COVERAGE**

[OAR Docket #07-665]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

317:45-1-2 through 317:45-1-3 [AMENDED]

317:45-1-4 [NEW]

Subchapter 3. O-EPIC PA Carriers

Subchapter 5. O-EPIC PA Qualified Health Plans

317:45-5-1 [AMENDED]

Subchapter 9. O-EPIC PA Employee Eligibility

317:45-9-3 [AMENDED]

317:45-9-5 [REVOKED]

317:45-9-7 [AMENDED]

Subchapter 11. O-EPIC IP

Part 1. Individual Plan Providers

317:45-11-1 through 317:45-11-2 [NEW]

Part 5. O-EPIC Individual Plan Member Eligibility

317:45-11-21 through 317:45-11-28 [NEW]

(Reference APA WF # 06-08)

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-665; filed 4-4-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 75. CHILD WELFARE**

[OAR Docket #07-643]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. General Provisions of Child Welfare Services
 - Part 1. Scope and Applicability
 - 340:75-1-12.2 [AMENDED]
 - 340:75-1-18 through 340:75-1-18.1 [AMENDED]
 - Part 3. Child Welfare Confidentiality
 - 340:75-1-44 [AMENDED]
- Subchapter 4. Family-Centered and Community Services
 - Part 1. Voluntary Family-Centered Services
 - 340:75-4-12.1 through 340:75-1-12.2 [AMENDED]
 - 340:75-4-13 [AMENDED]
- Subchapter 6. Permanency Planning
 - Part 5. Permanency Planning Services
 - 340:75-6-31 [AMENDED]
 - 340:75-6-31.5 [AMENDED]
 - Part 7. Case Plans
 - 340:75-6-40.2 through 340:75-6-40.5 [AMENDED]
 - Part 8. Role of the Child Welfare Worker
 - 340:75-6-48 [AMENDED]
 - Part 11. Permanency Planning and Placement Services
 - 340:75-6-85 [AMENDED]
 - 340:75-6-85.2 [AMENDED]
 - 340:75-6-85.4 through 340:75-6-85.6 [AMENDED]
 - 340:75-6-86 [AMENDED]
 - 340:75-6-88 through 340:75-6-89 [AMENDED]
- Subchapter 8. Therapeutic Foster Care and Developmental Disabilities Services
 - Part 1. Therapeutic Foster Care
 - 340:75-8-1 [AMENDED]
 - 340:75-8-6 through 340:75-8-11 [AMENDED]
 - Part 3. DDS Services for ~~Children in Custody~~ ~~Children~~
 - 340:75-8-36 through 340:75-8-39 [AMENDED]
- Subchapter 15. Adoptions
 - Part 14. Post Adoption Services
 - 340:75-15-128.1 through 340:75-15-128.3 [AMENDED]
 - 340:75-15-128.5 through 340:75-15-128.6 [AMENDED]
- Subchapter 16. Mental Health Treatment Services
 - Part 1. Inpatient Mental Health Treatment
 - 340:75-16-29 through 340:75-16-32 [AMENDED]
 - 340:75-16-34 through 340:75-16-37 [AMENDED]
 - Part 3. Outpatient Behavioral Health Care Services
 - 340:75-16-45 [AMENDED]
- Subchapter 19. Working with Indian Children
 - 340:75-19-1 through 340:75-19-4 [AMENDED]
 - 340:75-19-11 [AMENDED]
 - 340:75-19-16 [AMENDED]
 - 340:75-19-22 [AMENDED]
 - 340:75-19-26 [AMENDED]

340:75-19-28 through 340:75-19-31 [AMENDED]
340:75-19-33 [AMENDED]
(Reference APA WF 06-09 and 06-23)

GUBERNATORIAL APPROVAL:

February 23, 2007

[OAR Docket #07-643; filed 4-3-07]

**TITLE 457. OKLAHOMA STRATEGIC MILITARY PLANNING COMMISSION
CHAPTER 10. ADMINISTRATIVE OPERATIONS AND PROGRAM IMPLICATION**

[OAR Docket #07-569]

RULEMAKING ACTION:

Gubernatorial Approval of permanent rules

RULES:

- Subchapter 1. General Provisions [NEW]
 - 457:10-1-1 through 10-1-4 [NEW]
- Subchapter 3. Organization and Administration [NEW]
 - 457:10-3-1 through 10-3-3 [NEW]
- Subchapter 5. Cooperative Program with Local Governmental Entities [NEW]
 - 457:10-5-1 through 10-5-2 [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-569; filed 3-28-07]

**TITLE 490. OKLAHOMA STATE BOARD OF EXAMINERS FOR ~~NURSING HOME LONG TERM CARE~~ ADMINISTRATORS
CHAPTER 1. ADMINISTRATIVE OPERATIONS**

[OAR Docket #07-582]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. General Provisions
 - 490:1-1-1. Purpose [AMENDED]
 - 490:1-1-2. Definitions [AMENDED]
- Subchapter 3. Oklahoma State Board of Examiners for ~~Nursing Home~~ Long Term Care Administrators [AMENDED]
 - 490:1-3-1. Organization [AMENDED]
 - 490:1-3-2. Officers and committees [AMENDED]
 - 490:1-3-3. Meeting of the Board [AMENDED]
 - 490:1-3-6. Continuing Education Programs and Training Programs [REVOKED]
 - 490:1-3-7. Administrator University [REVOKED]
 - 490:1-3-8. Executive Director [NEW]

Gubernatorial Approvals

- 490:1-3-9. Waiver of one administrator per facility rule [NEW]
Subchapter 5. ~~Complaints/Referrals~~ Investigative Procedures [AMENDED]
490:1-5-2. Receipt of ~~Complaints/Referrals~~ complaints [AMENDED]
490:1-5-2.1. Receipt of referrals [NEW]
490:1-5-3. Investigation of ~~complaints/referrals~~ complaints [AMENDED]
490:1-5-4. Preparation of investigative report [AMENDED]
490:1-5-5. Board decision [AMENDED]
490:1-5-6. Notice [AMENDED]
490:1-5-7. Hearing [AMENDED]
490:1-5-7.1. Administrative fines [NEW]
490:1-5-8. Reporting [AMENDED]
Subchapter 6. Administrator Registry
490:1-6-1. ~~Administrator—Registry~~ General provisions [AMENDED]
Subchapter 7. Fees and Deposits
490:1-7-1. Fees and Deposits [AMENDED]
490:1-7-2. Schedule of fees [NEW]
Subchapter 9. Continuing Education [NEW]
490:1-9-1. General provisions for continuing education programs [NEW]
490:1-9-2. Criteria for continuing education programs [NEW]
490:1-9-3. Approval of continuing education programs [NEW]
490:1-9-4. Continuing education requirements [NEW]
490:1-9-5. Auditing of continuing education hours [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-582; filed 3-29-07]

TITLE 490. OKLAHOMA STATE BOARD OF EXAMINERS FOR NURSING HOME LONG TERM CARE ADMINISTRATORS CHAPTER 10. RULES AND REGULATIONS FOR NURSING HOME LONG TERM CARE ADMINISTRATORS

[OAR Docket #07-583]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. Licensing of ~~Nursing Home~~ Long Term Care Administrators
490:10-1-1. Purpose [AMENDED]
490:10-1-2. Definitions [REVOKED]
490:10-1-3. ~~Personal—qualifications—of—applicants~~ Qualifications for initial licensure [AMENDED]
490:10-1-4. ~~Other qualifications for licensure of applicants~~ Qualifications for licensure by reciprocity [AMENDED]

- 490:10-1-5. Qualifications for a provisional license [NEW]
490:10-1-6. Administrator responsibilities [AMENDED AND RENUMBERED TO 490:10-13-2]
490:10-1-7. Waiver of rule [REVOKED]
490:10-1-8. Administrator code of ethics [AMENDED AND RENUMBERED TO 490:10-13-1]
490:10-1-9. Inactive license [NEW]
490:10-1-10. Requirements for reinstatement from inactive status [NEW]
490:10-1-11. Requirements for restoration from suspended status [NEW]
Subchapter 3. Application for Licensure
490:10-3-1. Application ~~process~~ for initial licensure, reciprocity, or provisional license
490:10-3-2. National examination [NEW]
490:10-3-3. State standards examination [NEW]
490:10-3-4. Admission to state and national examinations [NEW]
490:10-3-5. Application for licensure renewal [NEW]
490:10-3-6. Licensure term [NEW]
Subchapter 5. ~~Licensure Expiration, Renewal, Denial, Revocation and Suspension Discipline~~
490:10-5-1. Expiration [AMENDED AND RENUMBERED TO 490:10-3-6]
490:10-5-2. Renewal [AMENDED AND RENUMBERED TO 490:10-3-5]
490:10-5-3. ~~Denial, revocation and suspension~~ Disciplinary action
490:10-5-4. Auditing of continuing education [REVOKED]
490:10-5-5. Summary suspension [NEW]
Subchapter 7. Administrator University [NEW]
490:10-7-3. General provisions [NEW]
Subchapter 8. Administrator-in-Training (AIT)
490:10-8-1. Training requirement [REVOKED]
490:10-8-2. Application [AMENDED]
490:10-8-5. Preceptor qualifications and agreement [AMENDED]
490:10-8-7. Module reports [AMENDED]
490:10-8-9. Preceptor's checklist [AMENDED]
490:10-8-13. AIT time on the job [AMENDED]
490:10-8-14. AIT exempt status [AMENDED]
490:10-8-15. Admission to national and state exams [AMENDED AND RENUMBERED TO 490:10-3-4]
490:10-8-16. Refusal to approve or renew preceptor or intern assignment [AMENDED]
490:10-8-17. Supervision of more than one AIT restricted [AMENDED]
Subchapter 9. License Status [REVOKED]
490:10-9-1. License status [REVOKED]
490:10-9-2. Reinstatement [REVOKED]
Subchapter 10. Fee Schedule [REVOKED]
490:10-10-1. Fee Schedule [REVOKED]
Subchapter 13. Standards for Administrators [NEW]
490:10-13-1. Administrator code of ethics [NEW]
490:10-13-2. Administrator responsibilities [NEW]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-583; filed 3-29-07]

**TITLE 720. STATE TEXTBOOK
COMMITTEE
CHAPTER 10. TEXTBOOK SELECTION**

[OAR Docket #07-644]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. Bidding Procedures

720:10-3-7. Free Materials [AMENDED]

GUBERNATORIAL APPROVAL:

March 15, 2007

[OAR Docket #07-644; filed 4-3-07]

Emergency Adoptions

An agency may adopt new rules, or amendments to or revocations of existing rules, on an emergency basis if the agency determines that "an imminent peril exists to the preservation of the public health, safety, or welfare, or that a compelling public interest requires an emergency rule[s] [A]n agency may promulgate, at any time, any such [emergency] rule[s], provided the Governor first approves such rule[s]" [75 O.S., Section 253(A)].

An emergency action is effective immediately upon approval by the Governor or on a later date specified by the agency in the preamble of the emergency rule document. An emergency rule expires on July 15 after the next regular legislative session following promulgation, or on an earlier date specified by the agency, if not already superseded by a permanent rule or terminated through legislative action as described in 75 O.S., Section 253(H)(2).

Emergency rules are not published in the *Oklahoma Administrative Code*; however, a source note entry, which references the *Register* publication of the emergency action, is added to the *Code* upon promulgation of a superseding permanent rule or expiration/termination of the emergency action.

For additional information on the emergency rulemaking process, see 75 O.S., Section 253.

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 15. ANIMAL INDUSTRY

[OAR Docket #07-568]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 45. Brucellosis in Cervidae
Part 13. Certified Brucellosis-Free Cervid Herds
35:15-45-131 [AMENDED]
35:15-45-132 [AMENDED]

AUTHORITY:

State Board of Agriculture and the Oklahoma Agricultural Code; 2 O.S. 2001 §§ 2-4(2), (7), (17), (27) and (29); 6-2; and 6-291

DATES:

Adoption:

February 15, 2007

Approved by Governor:

March 15, 2007

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2008 unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

This rule is necessary to protect the cervid industry in Oklahoma from unnecessary injury or fatality to cervidae. Due to the fractious nature of cervidae, frequent testing often results in injury or death to the animals, and also can result in injury to the handler. Due to the potential danger resulting from the more frequent testing of these animals, the Board finds that a compelling public interest exists for the approval of this emergency rule.

ANALYSIS:

Testing of cervidae for Brucellosis was on the same schedule as Tuberculosis for maintenance of Certified Brucellosis Free herd status. The Tuberculosis requirements were changed earlier this year from three tests to two tests annually and to increase the time period for recertification from two years to three years. This rule proposes to adopt the same time periods as the Tuberculosis testing for Brucellosis testing in cervidae.

CONTACT PERSON:

Dr. Becky Brewer-Walker, (405) 522-6142

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

SUBCHAPTER 45. BRUCELLOSIS IN CERVIDAE

PART 13. CERTIFIED BRUCELLOSIS-FREE CERVID HERDS

35:15-45-131. Qualifying methods

(a) Certified Brucellosis-Free cervid herd status ~~must~~shall include all test-eligible animals in the herd. A certified herd may be purchased, or a herd may qualify for Certified Brucellosis-Free cervid herd status by complete herd testing.

(b) For initial certification, all sexually intact test-eligible cervids in the herd ~~must~~shall have ~~three~~two consecutive negative tests for brucellosis not less than ~~9~~nine (9) nor more than ~~15~~fifteen (15) months apart.

(c) A herd test is not required if the purchased animals remain on the same premises. Upon request and with proof of purchase, a new certificate ~~will~~may be issued in the new owner's name. The anniversary date and the herd number ~~will~~ remain the same.

(d) If part or all of the purchased herd is moved directly to premises that have no other animals, the herd may retain Certified Brucellosis-Free cervid herd status without a test. The anniversary date of the new herd ~~will be~~is the test date of the most recent complete herd test.

35:15-45-132. Conditions

(a) A herd is certified for ~~24~~thirty-six (36) months.

(b) For continuous certification, all test-eligible animals in the herd ~~must~~shall have a negative test for brucellosis between ~~24~~thirty-three (33) and ~~27~~thirty-nine (39) months after the last certification date. If suspects or reactors are found on recertification testing, certification status ~~will~~shall be terminated and a herd investigation ~~will be~~ initiated.

(c) ~~Animals~~Test-eligible animals originating in a Certified Brucellosis-Free cervid herd and moving into a Certified Brucellosis-Free cervid herd ~~do not need to be tested prior to movement. However, if the animals are not tested prior to movement, the test-eligible animals will~~ shall be tested between ~~60~~sixty (60) and ~~180~~one hundred eighty (180) days after addition to the certified herd.

(d) Animals purchased from cervid herds not Certified Brucellosis-Free ~~cannot~~shall not be considered part of the certified herd until three (3) blood tests have been conducted. The first

Emergency Adoptions

test shall occur within ~~30~~thirty (30) days prior to movement from the herd ~~of~~ origin, the second test between ~~60~~sixty (60) and ~~180~~one hundred eighty (180) days after addition to the Certified Brucellosis-Free cervid herd, and the third test as a part of the next complete herd blood test for recertification following the second test.

(e) If a herd consists of both cattle and Cervidae, the requirements for herd certification ~~must~~shall be consistent with those for cattle as described in 35:15-17-64 through 35:15-17-66.

(f) The State animal health official and the APHIS AVIC ~~will~~may issue a Certified Brucellosis-Free cervid herd certificate when the herd first qualifies. For recertification, the State animal health official ~~will~~may issue a renewal form, ~~which must also be approved by the APHIS AVIC.~~

[OAR Docket #07-568; filed 3-28-07]

TITLE 245. STATE BOARD OF LICENSURE FOR PROFESSIONAL ENGINEERS AND LAND SURVEYORS CHAPTER 2. ADMINISTRATIVE OPERATIONS

[OAR Docket #07-653]

RULEMAKING ACTION:

Emergency adoption

RULES:

245:2-1-18 [AMENDED]

AUTHORITY:

59 O.S. 475.1 et seq; 65 O.S., 1991 Sections 3-116 et seq; 75 O.S. Sections 301 et seq; State Board of Licensure for Professional Engineers and Land Surveyors

DATES:

Adoption:

March 2, 2007

Approved by Governor:

April 2, 2007

Effective:

July 1, 2007

Expiration:

Effective through July 14, 2008 unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

AVAILABILITY:

Copies of the rules may be obtained by contacting Kathy Hart at the Board office, 201 N.E. 27th St., Room 120, Oklahoma City, OK 73105. Copies of the rules may also be downloaded from our website at www.pels.state.ok.us.

FINDING OF EMERGENCY:

Revisions to OAC 245:2-1-18 were proposed this legislative session and withdrawn after submittal to the Governor and Legislature because of a discrepancy found between the statutes and rules regarding fees. Because a fee increase was being proposed to offset a deficit that the agency has been experiencing each year and to exercise fiscal responsibility for this agency, the Board voted unanimously that under these extraordinary circumstances an emergency rule should be adopted. The public and licensees have been given the opportunity to review the proposed fee revisions in public notices and a public hearing was conducted during the permanent rulemaking process. The only revision to this emergency rule as opposed to the proposed permanent rules was a reduction to an application fee to be in compliance with the statutes. No opposition was presented to the Board in writing or at the public hearing regarding the proposed permanent rule.

ANALYSIS:

The proposed revisions to Chapter 2, Subchapter 1 are as follows:

(1) Revise schedule of fees and penalties, with an effective date of July 1, 2007.

CONTACT PERSON:

Kathy Hart (405) 521-2874 ext 24

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), WITH A LATER EFFECTIVE DATE OF JULY 1, 2007:

245:2-1-18. Fees and penalties

(a) Schedule of fees and penalties, effective July 1, 2007, are as follows:

(1) Application:

(A) Original

(i) Engineer/Surveyor - \$100.00

(ii) Intern - \$25.00

(iii) Firm - ~~\$150.00~~\$200.00

(B) Re-license

(i) Engineer/Surveyor - \$100.00

(ii) Intern - \$25.00

(iii) Firm - ~~\$150.00~~\$200.00

(C) Requalifications

(i) Engineer/Surveyor - \$100.00

(ii) Intern - \$25.00

(2) Biennial renewals:

(A) Individuals (Renewal fees are waived for Oklahoma licensed engineers and surveyors at 70 years old. Individuals must be 70 years old prior to their biennial renewal date and return the renewal form sent by the Board to qualify.)

(i) Engineer/Surveyor - ~~\$100.00~~\$150.00

(ii) Intern - WAIVED

(B) Firm - ~~\$100.00~~\$200.00

(3) Reinstatement penalty (in addition to the renewal fee): The following reinstatement penalty schedule refers to payments received by the Board within the prescribed number of days following the expiration date of the renewal:

(A) 1 - ~~90~~60 days:

(i) Engineer/Surveyor - ~~\$50.00~~\$100.00

(ii) Firm - ~~\$50.00~~\$100.00

(B) ~~91~~61 - 120 days:

(i) Engineer/Surveyor - ~~\$100.00~~\$150.00

(ii) Firm - ~~\$100.00~~\$150.00

(C) 121 - 180 days:

(i) Engineer/Surveyor - ~~\$150.00~~\$250.00

(ii) Firm - ~~\$150.00~~\$250.00

(4) Re-examination application:

(A) Engineer/Surveyor - \$50.00

(B) Intern - \$10.00

(5) Temporary permit (Engineering) - ~~\$500.00~~\$750.00

(6) Administrative fee for returned checks:

(A) Engineer/Surveyor - \$25.00

(B) Intern - \$25.00

(C) Firm - \$25.00

- (D) Public - \$25.00
 - (7) Duplicate certificate:
 - (A) Engineer/Surveyor - \$15.00
 - (B) Intern - \$15.00
 - (C) Firm - \$15.00
 - (8) Roster:
 - (A) Intern - \$10.00
 - (B) Firm - \$10.00
 - (C) Public - \$10.00
 - (9) Transcript of hearing - Actual cost
 - (10) Copy of public records (per page):
 - (A) Engineer/Surveyor - \$.25
 - (B) Intern - \$.25
 - (C) Firm - \$.25
 - (D) Public - \$.25
- (b) The Board shall make no refunds of any fees or penalties to any applicant or licensee.
- (c) These fees and penalties apply to the Rules in this Chapter and Chapter 15 of this Title.
- (1) The administrative fee for returned checks shall be applied to any check returned to the Board for insufficient funds.
 - (2) Any such check returned to the Board shall be replaced with a cashier's check or money order within ten (10) days following notification from the Board of the returned check.

[OAR Docket #07-653; filed 4-3-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 45. OKLAHOMA EMPLOYER
AND EMPLOYEE PARTNERSHIP FOR
INSURANCE COVERAGE**

[OAR Docket #07-683]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 11. O-EPIC IP [NEW]
Part 3. O-EPIC IP Member Health Care Benefits [NEW]
317:45-11-10 through 317:45-11-11 [NEW]
(Reference APA WF # 06-65)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; O.S.S. §68-302-5 et seq.; and 42 CFR 440.100

DATES:

Adoption:

February 8, 2007

Approved by Governor:

March 2, 2007

Effective:

Immediately upon Governor's approval or April 1, 2007 whichever is later

Expiration:

Effective through July 14, 2007, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 11. O-EPIC IP [NEW]
Part 3. O-EPIC IP Member Health Care Benefits [NEW]
317:45-11-10. through 45-11-11. [NEW]

(Reference APA WF # 06-55)

Gubernatorial approval:

January 30, 2007

Register publication:

24 Ok Reg 700

Docket number:

07-335

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to add a limited dental benefit package for pregnant women to the O-EPIC Individual Plan. An enhanced dental benefit for pregnant women was extended to SoonerCare members effective April 1, 2007, with rule revisions approved at the December 14, 2006, OHCA Board meeting. Emergency revisions are needed to expand the perinatal dental benefit to include the O-EPIC Individual Plan participants effective April 1, 2007.

ANALYSIS:

O-EPIC Individual Plan rules are revised to add a limited group of dental services for pregnant women to the benefit package. Studies have indicated that treating periodontal disease during pregnancy has a positive effect on birth outcomes. At the December 14, 2006, OHCA Board meeting, emergency rules were approved to add this same dental benefit for pregnant SoonerCare members effective April 1, 2007. O-EPIC is funded through a portion of monthly proceeds from the Tobacco Tax that is collected and dispersed through the Health Employee and Economy Improvement Act (HEEIA) Revolving Fund. Emergency revisions are needed to expand the perinatal dental benefit to also include the O-EPIC Individual Plan participants. Other revisions have been incorporated due to superseding emergency rules previously approved by the Governor on January 30, 2007.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR APRIL 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 11. O-EPIC IP

PART 3. O-EPIC IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. O-EPIC IP benefits

(a) All O-EPIC IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section.

(b) A PCP referral is required to see any other provider with the exception of the following services:

- (1) behavioral health services;
- (2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;
- (3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
- (4) women's routine and preventive health care services;

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- (5) emergency medical condition as defined in OAC 317:30-3-1; and
- (6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.
- (c) O-EPIC IP covered benefits, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of \$1,000,000. Coverage includes:
- (1) Anesthesia / Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA).
- (2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
- (3) Chelation Therapy. Covered for heavy metal poisoning only.
- (4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): \$0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan): \$25 co-pay per scan.
- (5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a \$30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.
- (6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, 317:30-5-47 and 317:30-5-95; \$50 co-pay per admission.
- (7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a \$10 co-pay. This visit counts as an office visit.
- (8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; \$10 co-pay per visit.
- (9) Outpatient Hospital/Facility Services.
- (A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; \$25 co-pay per visit.
- (B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; \$10 co-pay per visit.
- (10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22. Nursery care paid separately under eligible child; \$50 inpatient hospital co-pay.
- (11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20; \$0 co-pay.
- (12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901; \$0 co-pay.
- (13) Immunizations for Adults. Covered in accordance with OAC 317:30-5-2; \$10 co-pay per immunization.
- (14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.
- (15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; \$0 co-pay.
- (16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital \$50 or Outpatient Hospital/Facility; \$25 co-pay applies.
- (17) Mental Health Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1; \$50 co-pay per admission.
- (18) Mental Health Treatment (Outpatient). Covered in accordance with OAC 317:30-5-241; \$10 co-pay per visit.
- (19) Substance Abuse Treatment (Outpatient). Covered in accordance with OAC 317:30-5-241; \$10 co-pay per visit.
- (20) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5, Part 17. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a \$15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; \$5 co-pay for durable/non-durable supplies and \$25 co-pay for durable medical equipment.
- (21) Diabetic Supplies. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$5 co-pay per prescription.
- (22) Oxygen. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$5 co-pay per month.
- (23) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; \$5/\$10 co-pay per prescription.
- (24) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-77.2; \$5/\$10 co-pay per product.
- (25) Nutrition Services. Covered in accordance with OAC 317:30-5-1076; \$10 co-pay per visit.
- (26) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5, Part 17; \$25 co-pay per prosthesis.
- (27) Surgery. Covered in accordance with OAC 317:30-5-8; \$50 co-pay per inpatient admission and \$25 co-pay per outpatient visit.
- (28) Home Dialysis. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$0 co-pay.
- (29) Parenteral Therapy. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$25 co-pay per month.
- (30) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57; \$0 co-pay.

- (31) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211(a)(3)(D)(i) and 317:30-5-41(2)(J)(iii).
- (32) Ultraviolet Treatment-Actinotherapy.
- (33) Fundus photography.
- (34) Perinatal dental care for pregnant women. Covered in accordance with OAC 317:30-5-696; \$0 co-pay.

317:45-11-11. O-EPIC IP non-covered services

Certain health care services are not covered in the O-EPIC IP benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

- (1) services that the member's PCP or O-EPIC does not consider medically necessary;
- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ and tissue transplant services;
- (4) treatment of obesity;
- (5) procedures, services and supplies related to sex transformation;
- (6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
- (8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (9) experimental procedures, drugs or treatments;
- (10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;

- (11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (12) physical medicine including speech, physical, occupational, chiropractic, acupuncture and osteopathic manipulation therapy;
- (13) hearing services;
- (14) transportation [emergent or non-emergent (air or ground)];
- (15) rehabilitation (inpatient);
- (16) cardiac rehabilitation;
- (17) allergy testing and treatment;
- (18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
- (19) hospice regardless of location;
- (20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (21) genetic counseling;
- (22) fertility evaluation/treatment/and services;
- (23) sterilization reversal;
- (24) Christian Science Nurse;
- (25) Christian Science Practitioner;
- (26) skilled nursing facility;
- (27) longterm care;
- (28) stand by services;
- (29) thermograms; and
- (30) abortions (for exceptions, refer to OAC 317:30-5-6).

[OAR Docket #07-683; filed 4-4-07]

Permanent Final Adoptions

An agency may promulgate rules on a permanent basis upon "final adoption" of the proposed new, amended, or revoked rules. "Final adoption" occurs upon approval by the Governor and the Legislature, or upon enactment of a joint resolution of approval by the Legislature. Before proposed permanent rules can be reviewed and approved/disapproved by the Governor and the Legislature, the agency must provide the public an opportunity for input by publishing a Notice of Rulemaking Intent in the *Register*.

Permanent rules are effective ten days after publication in the *Register*, or on a later date specified by the agency in the preamble of the permanent rule document.

Permanent rules are published in the *Oklahoma Administrative Code*, along with a source note entry that references the *Register* publication of the permanent action.

For additional information on the permanent rulemaking process, see 75 O.S., Sections 303, 303.1, 303.2, 308 and 308.1.

TITLE 55. BOARD OF GOVERNORS OF THE LICENSED ARCHITECTS, LANDSCAPE ARCHITECTS AND INTERIOR DESIGNERS OF OKLAHOMA CHAPTER 10. LICENSURE AND PRACTICE OF ARCHITECTS, AND LANDSCAPE ARCHITECTS AND REGISTRATION OF INTERIOR DESIGNERS

[OAR Docket #07-716]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 1. General Provisions [AMENDED]
- Subchapter 3. Administrative Operations [AMENDED]
- Subchapter 5. Application and Eligibility for Licensing or Registration [AMENDED]
- Subchapter 7. Examination [AMENDED]
- Subchapter 9. Licensing and Registration [AMENDED]
- Subchapter 11. Rules of Professional Conduct [AMENDED]
- Subchapter 13. Organizational Practice [AMENDED]
- Subchapter 15. Violations [AMENDED]
- Subchapter 17. Continuing Education Requirements [AMENDED]

AUTHORITY:

Board of Governors of the Licensed Architects, Landscape Architects and Interior Designers of Oklahoma; 59 O.S., 46.1

DATES:

Comment period:

January 2, 2007 through February 1, 2007

Public hearing:

February 2, 2007

Adoption:

February 2, 2007

Submitted to Governor:

February 2, 2007

Submitted to House:

February 2, 2007

Submitted to Senate:

February 2, 2007

Gubernatorial approval:

March 15, 2007

Legislative approval:

Failure of the Legislature to disapprove the rules resulted in approval on March 28, 2007

Final adoption:

March 28, 2007

Effective Date:

May 11, 2007

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed revisions to the Rules are being made to implement changes to the Oklahoma State Architectural and Interior Designers Act codified at 59

O.S. § 46.1 et. seq., as passed by the legislative session in SB 1991 and HB 2379.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1 (A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

55:10-1-1. Purpose

The Rules of this Chapter are set forth for the purpose of interpreting and implementing the Act, establishing the Board and conferring upon it responsibility for registration of licensing Architects, and Landscape Architects, and registering Interior Designers. The Act and Rules also require regulation regulating of the practice of architecture and landscape architecture and enforcement of the Act. The Rules of this Chapter are known and cited as OAC 55:10.

55:10-1-3. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"**Act**" means the currently enacted and effective State Architectural Act, legislation codified at 59 O.S., Section 46.1, et seq.

"**Applicant**" means an individual who has submitted an application for a license—License or Registration to the Board.

"**Architect**" means an individual who engages in the practice of architecture and, for the purpose of these Chapter 10 Rules, holds a License or Certificate of Registration issued by the Board.

"**Architect(s) of Record**" means a Registrant—Licensee currently licensed as an Architect or Landscape Architect and in good standing with this Board, that has met statutory and OAC 55:10 requirements, who is directly responsible to this the Board for the firm practice, filings, and paying of all fees, penalties and submitting all documents.

"**ARE**" means the current architect registration examination; prepared by NCARB and adopted by the Board as the

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~~licensing examination to be used in determining a Candidate's qualifications to practice architecture.~~

"Assembly hall" means included, but not limited to, all buildings or portions of buildings used for gathering together 50 or more persons for such purposes as deliberation, worship, entertainment, amusement, or awaiting transportation. Assembly occupancies include:

- (A) Armories
- (B) Assembly halls
- (C) Auction rooms
- (D) Auditoriums
- (E) Bowling lanes
- (F) Churches
- (G) Club rooms
- (H) College and university classrooms, 50 persons and over
- (I) Conference rooms
- (J) Courtrooms
- (K) Dance halls
- (L) Department stores
- (M) Drinking establishments
- (N) Exhibition halls
- (O) Gymnasiums
- (P) Libraries
- (Q) Mortuary chapels
- (R) Motion picture theaters
- (S) Museums
- (T) Passenger stations and terminals of air, surface, underground, and marine public transportation facilities
- (U) Pool rooms
- (V) Recreation piers
- (W) Restaurants
- (X) Shopping centers
- (Y) Skating rinks
- (Z) Supermarkets
- (AA) Theaters

"Board" means the Board of Governors of the Licensed Architects, ~~and Landscape Architects and Interior Designers~~ of Oklahoma.

"Building types" means the types of buildings found in O.S. 59, Section 46.21b of the Act.

"Candidate" means an individual who has been approved to sit for the examinations given by the Board, or who has passed said examinations, but has not been issued a License or Certificate of Registration.

"CE" means continuing education.

"Certificate of Authority" means the authorization granted by the Board for individuals to practice or offer to practice architecture or landscape architecture in the state through an Entity.

"Certificate of Registration" means the authority granted by the Board to an individual Registrant to ~~practice or offer to practice architecture or landscape architecture offer services as interior design and represent the individual as an Interior Designer~~ in the state.

"Certificate of Title" means the authorization granted by the Board to an Entity to use the title Interior Designer or offer services as interior design.

"CEU" means a continuing education unit of one Contact Hour.

"CIDA" means Council of Interior Design Accreditation or its successor.

"CLARB" means Council of Landscape Architectural Registration Boards or its successor.

"Contact Hour" as used in the continuing education requirements means one clock hour of not less than 50 minutes.

"Direct supervision" means working conditions where a licensed Architect, Landscape Architect or Interior Designer is in each office and is a resident Licensee or Registrant regularly employed in that office, supervising the intern or employees and is directly responsible for all tactical and technical decisions on projects.

"Dormitories" means those occupancies in which sleeping accommodations are provided for normal residential purposes and include all buildings designed to provide sleeping accommodations. Dormitory occupancies are in the following groups:

- (A) Apartments/apartments for elderly
- (B) Correction centers
- (C) Detention Centers
- (D) Dormitories
- (E) Hotels/motels
- (F) Jails
- (G) Lodging or rooming houses
- (H) Orphanages for age 6 years and older
- (I) Penal institutions
- (J) Reformatories
- (K) Residential restrained care institutions

"Educational buildings" means all buildings used for the gathering of groups of 6 or more persons for purposes of instruction. Educational occupancies include:

- (A) Academies
- (B) Child day care facilities
- (C) Colleges and universities
- (D) Kindergartens
- (E) Nursery schools
- (F) Schools.

"Entity" means any group of individuals joined together to offer, or contract for services to ~~or~~ practice architecture, ~~or~~ landscape architecture or use the term interior design or the title of Interior Designer. Entity shall include individuals, partnerships, firms, associations, corporations, limited liability companies and limited liability partnership and any other business or professional group recognized under the Act and approved by the Board ~~or engage in the practice of architecture or landscape architecture.~~

"Examination" means the current licensing and Registration examinations administered by this Board, or its designee, for Architects, ~~and Landscape Architects or Interior Designers.~~

"Factories" means factories making products of all kinds and properties devoted to operations such as processing, assembling, mixing, packaging, finishing or decorating, and repairing, including, among others, the following:

- (A) College and university non-instructional laboratories
- (B) Creameries
- (C) Dry-cleaning plants
- (D) Factories of all kinds
- (E) Laboratories
- (F) Laundries
- (G) Smokehouses.

"Fiscal Year" means July 1 through June 30.

"Hospitals" means occupancies designed for purposes of medical or other treatment or care of suffering from physical or mental illness, disease or infirmity; or for the care of infants, convalescents, or infirm aged persons. Hospital occupancies are treated in the following groups:

- (A) Ambulatory surgical facilities
- (B) Health care facilities:
 - (i) Hospitals
 - (ii) Nursing homes [Attorney General Opinion 64-108, as modified by Attorney General Opinion 93-036 (1994)]
- (C) Mentally-retarded care institutions
- (D) Residential custodial care:
 - (i) Homes for the infirm aged
 - (ii) Nurseries
- (E) Supervisory care facilities.

"IDP" means Intern Development Program.

"IDEP" means the Interior Design Experience Program.

"Intern" means an individual in the process of obtaining training credits acceptable to the Board in order to complete requirements to pursue licensing or Registration.

"Interior Designer" means an individual registered by the Board to use the title Interior Designer.

"Interior Designer of Record" means a registered Interior Designer in good standing with this Board, that has met statutory and OAC 55:10 requirements, and who is directly responsible to the Board for the activities, filings, paying all fees, penalties and submitting all documents for the Entity having been issued the Certificate of Title.

"LAAB" means Landscape Architectural Accrediting Board or its successor.

"LARE" means the current Landscape Architect registration examination prepared by CLARB and adopted by the Board as the licensing examination to be used in determining a Candidate's qualifications to practice landscape architecture.

"Landscape Architect" means an individual currently-licensed to practice landscape architecture in Oklahoma.

"License" means the issuance of a Certificate of Registration or Licensure to an individual by the Board a License to practice architecture or landscape architecture issued by the Board and permission to use the title Architect or Landscape Architect.

"Licensee" means Registrant a licensed Architect or Landscape Architect that practices architecture or landscape architecture.

"Licensure" means Registration and shall have the meaning set forth in the Act.

"NAAB" means the National Architectural Accrediting Board or its successor.

"NASAD" means the National Association of the Schools of Art and Design or its successor.

"NCARB" means National Council of Architectural Registration Boards or its successor.

"NCIDQ" means National Council for Interior Designers Qualification, the organization administering examinations and setting model practice standards for the Registration of Interior Designers, or its successor.

"Reciprocal License" means a License granted by the Board to an individual issued to practice architecture or landscape architecture and granting use of the term Architect or Landscape Architect or any derivation of the word by reciprocity based on a current License in good standing in another jurisdiction meeting the requirements for licensing in this State.

"Reciprocal Registration" means a registration granted by the Board to an individual to use the title Interior Designer or any derivation of the word based on the License or Registration in good standing in another jurisdiction meeting the requirements for Registration in this state.

"Registrant" means an individual licensed-registered by the Board to use the title Interior Designer, as a designation of the individual's profession, practice architecture or landscape architecture.

"Registration" means Licensure the authority granted by this Board to a qualified individual to use the term Interior Designer unless exempt by the Act from Registration.

"Resident State" means the state where the Applicant, Candidate, Licensee or Registrant legally resides.

"Responsible Control" shall have the meaning set forth in the Act.

"Rules" means this Oklahoma Administrative Code, Title 55, Chapter 10 Rules.

"Sole proprietorship" means the only owner of a firm, licensed or registered as an individual by this the Board to practice architecture or landscape architecture.

"Sponsor" means an individual, organization, association, institution or other entity that provides an educational activity for the purpose of fulfilling the continuing educational requirements of the Board.

"Stadium" means all facilities designed for the purpose of viewing sports events. Stadium facilities include:

- (A) Bleachers
- (B) Coliseums
- (C) Grandstands.

"Technical submissions" means designs, drawings, specifications, studies and other technical reports prepared in the course of the practice of architecture or landscape architecture.

"UNE" means the former Landscape Architect registration-licensing examination, prepared by CLARB and adopted by this the Board as the licensing examination.

"Warehouses" means all buildings or structures utilized primarily for the storage or sheltering of goods, merchandise, products and vehicles. Included in this occupancy group are:

- (A) Cold storage
- (B) Freight terminals
- (C) Hangars

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- (D) ~~Parking garages~~
- (E) ~~Truck and marine terminals~~
- (F) ~~Warehouses.~~

55:10-1-4. Statutory charges of the Board

Provisions of the Act charge the Board with enforcement and adoption of all reasonable and necessary ~~rules and regulations~~ Rules which it may deem advisable and empowers the Board with authority to deny, suspend, revoke or refuse to renew Licenses, Certificates of Registrations, and Certificates of Authority and Certificates of Title for certain causes. The Act also empowers the Board with civil fining power and does not preclude the Board from using any necessary legal proceedings to enforce its decisions.

SUBCHAPTER 3. ADMINISTRATIVE OPERATIONS

55:10-3-1. Conduct of Board meetings

- (a) The Board may meet at such place within the State of Oklahoma as may be directed by the ~~Chairman~~ Chair or provided in the notice of call for any regular or special meeting and subject to the requirements of the Oklahoma Open Meeting Act, 25 O.S., Sections 301, et seq.
- (b) All meetings shall be conducted in accordance with the current edition of "Robert's Rules of Order".
- (c) Members of the Board may waive formal or written call or notice of meeting, and by the attendance at any meeting such members so attending shall be deemed to have waived all notice thereof.
- (d) A quorum shall consist of ~~five (5)~~ six (6) members but official action may not be taken upon any question unless ~~four (4)~~ five (5) members vote in accord.
- (e) In the absence of a quorum at any regular or special meeting those members of the Board in attendance shall recess such meeting to any later date.

55:10-3-2. Duties of Board Officers

- (a) The duties of the ~~Chairman~~ Chair and the Secretary-Treasurer are as defined in the Act.
- (b) The ~~Vice Chairman~~ Vice Chair shall, in the absence of the ~~Chairman~~ Chair, fulfill all responsibilities of the ~~Chairman~~ Chair and, if necessary, succeed the ~~Chairman~~ Chair without election during the then current year, and shall perform such other duties as the Board may prescribe.

55:10-3-3. Duties of the Executive Director

The Board shall designate an Executive Director who shall have possession, on behalf of the Board, of all the official records of the Board and who shall, under the supervision of the Board, perform such duties as the Board authorizes. The Executive Director shall keep updated information on the examinations and policies of NCARB, ~~and CLARB~~ or NCIDQ and report any and all other important information to the Board for consideration, review and action.

55:10-3-4. Reimbursement for travel

Members of the Board and staff shall be reimbursed for travel expenses incurred during Board business, as allowed by the State Travel Act ~~and approved by the Board.~~

55:10-3-6. Official records

Among other official records required by law, or by rules of other agencies in support of law, there shall be maintained by the Board accurate and current records including, but not limited to:

- (1) ~~Minutes of all meetings of the Board.~~
- (2) ~~Records of Registrants containing the name and registration number of all persons to whom certificates of registration are issued, date of original registration, the last known address of all current Registrants and renewals effected through biennial registration.~~
- (3) ~~Registrant files for each current Registrant containing the original application, relevant verification and evaluation data, record of examination grades, and when applicable, records of alleged violations, suspensions, revocations, refusal to renew, orders issued, hearing transcriptions and penalties levied.~~
- (4) ~~Certificate of Authority file containing the name of each current Entity holding a current certificate, the Architect(s) or Landscape Architect(s) of record, a record of all partners, directors, and/or members of the Entity, their registration number and state, if applicable, and the last known address.~~
- (5) ~~Financial records of funds budgeted, committed, spent, remaining and projections of appropriate request for consideration in budget development.~~

- (1) Minutes of all meetings of the Board.
- (2) Records of Licensees and Registrants containing the name and License or Registration number of all individuals to whom Licenses or Certificates of Registration have been issued and the date of original issuance.
- (3) Files for each current Licensee, Registrant, Applicant or Candidate containing relevant verification and evaluation data, a record of examination grades and the last known address of all current Licensees and Registrants.
- (4) Certificate of Authority and Certificate of Title files containing the name of each current Entity holding a current certificate, the Architect(s) of Record or Interior Designer(s) of Record, and the last known address.
- (5) Financial records of funds budgeted, committed, spent, remaining and projections of appropriate request for consideration in budget development.

55:10-3-7. Inactive records

All inactive records of the Board over three (3) years old, ~~except those files containing violations and penalties, shall~~ may be transferred to the Archives and Records Commission and disposed of according to that agency's current statutes and rules.

55:10-3-8. Public records

Except confidential records, records of the Board are open to public inspection and copying at any time during normal business hours. A nominal fee may be charged for copying. If extensive time consuming copying or records searches are required, the ~~person~~ individual requiring such information or copying must supply personnel to do the tasks required. All records copied or searched shall be kept in the order found and shall be put back in the files as such.

55:10-3-9. Confidential records

(a) The Act, at Section 46.24E, provides for certain records of the Board to be confidential and not open to the public for copying or viewing. They are:

- (1) Examination materials, before and after the examination is given;
- (2) File records of examination problem solutions;
- (3) Letters of inquiry and reference concerning Applicants;
- (4) Board inquiry forms concerning Applicants; and
- (5) Investigation files ~~where any investigation is still pending.~~

(b) Prior to presentment to the Board for formal or informal adjudication, any record, as defined in the Act ~~at Section 24A.3,~~ pertaining to any alleged violation(s) of the Act or these Chapter 10 Rules shall be deemed part of the file of an pending investigation, ~~and~~ confidential and not subject to disclosure.

(c) Upon request, the Board will examine its ~~pending~~ investigation files to determine the extent to which material contained in the said ~~pending~~ investigation file should be deemed not confidential and, therefore, may be disclosed. In all cases, the Board, upon inquiry, will confirm a complaint has or has not been received and that an investigation is pending or has been completed.

55:10-3-10. Filing and disposition of petitions for declaratory rulings

(a) Any ~~person~~ individual may file a request for a declaratory ruling by the Board as to the application or enforcement of any ~~rule~~ Rules or statute to a given set of circumstances. Such requests shall be in writing, signed by the ~~person~~ individual seeking the ruling, state the ~~rule~~ Rule or statute involved and contain a brief and concise statement of facts to which the ruling shall apply. Requests shall be submitted to the Board at its office, either in person or by mail and may be in any form that meets the requirements stated. The Board will consider the request at its next regular or special meeting unless the question has been resolved by prior ruling of the Board, in which event the petitioner shall be promptly notified of the prior ruling.

(b) The Board may defer action or hold such requests on its agenda pending any investigation or hearing which the Board might conduct. The Board shall issue the requested rulings promptly upon the determination thereof or send an explanation to the petitioner stating why a ruling will not be issued. Unless a ruling states otherwise, rulings contemplated herein shall constitute precedent for the purpose of the Board's application and enforcement of the ~~rules~~ Rule in this Chapter and

statutes until revoked or overruled by the Board or the Courts. Such rulings shall be indexed by statute section or ~~rule~~ Rules and shall be available for inspection by members of the public at the Board office. With respect to indexed rulings, the Board may delete nonessential or repetitive information and may edit any ruling to protect proprietary or confidential information.

55:10-3-11. NCARB, ~~and~~ CLARB and NCIDQ memberships and programs

The Board ~~shall~~ may maintain membership in NCARB, ~~and~~ CLARB or NCIDQ and their regional conferences. It is the intention of the Board, to the extent permitted under Oklahoma law, to support NCARB, ~~and~~ CLARB or NCIDQ programs. This Board will cooperate with NCARB, ~~and~~ CLARB or NCIDQ in furnishing transcripts of records, administering examinations and rendering assistance in establishing uniform standards of professional qualification.

55:10-3-12. Method of payments to Board

Payment of monies shall be made by personal check, money order, credit card, if applicable or cashiers check made payable to "~~The Oklahoma~~ Board of Architects". Notations, explaining the payment remitted, should be on the face of the check or within cover letters of submittal. A fee shall be charged for any payment returned for insufficient funds.

55:10-3-13. Fees and penalties

- (a) Schedule of fees and penalties are as follows:
- (1) Initial and subsequent biennial License, Registration or renewal fee -- ~~\$200.00~~ \$225.00
 - (2) Reciprocal License or Registration application fee -- \$100.00
 - (3) Examination & Retake application fee -- \$75.00
 - (4) Examination -- Actual Cost
 - (5) Late payment penalty -- \$25.00
 - (6) Returned (insufficient funds) check fee -- \$25.00
 - (7) Reinstatement penalty -- \$100.00
 - (8) Certificate of Authority and Certificate of Title application, revision or renewal fee -- ~~\$75.00~~ \$100.00
 - (9) Duplicate certificate -- ~~\$20.00~~ \$25.00
 - (10) Roster -- \$.25 per page
 - (11) Transcript of hearing -- Actual Cost plus \$25.00
 - (12) Copy of public records -- \$.25 per page
 - (13) Emeritus License -- All fees waived
 - (14) CE reinstatement penalty -- \$1000.00 (per biennial renewal period of noncompliance)
 - (15) Civil penalties -- Set by the Act
 - (16) Manual processing fee -- \$25.00 per transaction
 - (17) File Transfer fee -- \$75.00
 - (18) Readmission Application fee -- \$100.00

~~(b) CE reinstatement penalties are in addition to any other reinstatement penalties under these Chapter 10 Rules.~~

(b) Fee exemption based on temporary military deployment. The Board shall waive all fees, penalties and continuing education, if applicable, during the time Licensees, Registrants or Candidates are called to active military duty in the armed forces

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of the United States and deployed to a temporary military assignment. In order to obtain this exemption, the Licensees, Registrants or Candidates are required to submit to the Board office military documentation of such deployment. Upon receipt, the staff shall make a note to the file and the Licensees, Registrants or Candidates shall be placed on active military status for the duration of the abovementioned deployment. At the end of the temporary deployment, the Licensees, Registrants or Candidates shall submit to the Board office within ninety (90) days, military documentation that the individual has returned from deployment. The individual will then be returned to regular active status. All fees, penalties and continuing education, if applicable, will be waived until the beginning of the next biennial License or Registration period. This exemption from fees and penalties shall also apply to the Certificate of Authority or the Certificate of Title if the Licensee is the only Architect of Record or the Registrant is the only Interior Designer of Record associated with the Entity.

(c) **Readmission Application fee.** This fee applies to individuals who are re-applying for their License or Registration to be reinstated for any reason, or changing from emeritus to active status. This fee does not apply to OAC 55:10-3-13 (b), Certificates of Authority or Certificates of Title.

SUBCHAPTER 5. APPLICATION AND ELIGIBILITY FOR LICENSING OR REGISTRATION

55:10-5-2. Documents required for licensing a License or Registration by exam

Every individual applying for an initial License ~~registration~~ or Registration by examination shall submit (i) an original application to the Board, accompanied by the applicable fees in 55:10-3-13, a 2" x 3" passport quality photograph, original college transcript and the required reference forms verifying all training experience, or (ii) through NCARB, ~~or CLARB or NCIDQ~~, copies of ~~these the NCARB or CLARB~~ documents and an original Oklahoma application. Information submitted will be verified and evaluated and subsequent submissions may be required of the Applicant. The forms must be complete and properly executed over the signature of the Applicant.

55:10-5-3. Board action required

All applications submitted for ~~registration an initial License or Registration by examination~~ shall be approved or disapproved by the Secretary-Treasurer of the Board or Board action. Applications submitted for a License or Registration may be approved by the Secretary-Treasurer of the Board only if the application meets all requirements of the Act, these Rules and/or equivalent standards determined by the Board.

55:10-5-4. Evaluation criteria

(a) In the Board's evaluation of education and experience credits required, the ~~Intern's~~ application shall be subject to the following education and training requirement standards for the applicable profession:

(1) for Architects, as established by this Board based upon the current "NCARB Handbook for Interns and Architects," "NCARB Education Standard" and "Intern Development Program Guidelines";

(2) for Landscape Architects, by the evaluation of credits established for Landscape Architect interns in this Subchapter.

(1) for Architects, as established by this Board based upon the current "NCARB Handbook for Interns and Architects," "NCARB Education Standard" and "Intern Development Program Guidelines", the Act, these Rules and/or equivalent standards determined by the Board;

(2) for Landscape Architects, as established by current CLARB standards, the Act, these Rules and/or equivalent standards determined by the Board;

(3) for Interior Designers, as established by current NCIDQ standards, the Act, these Rules and/or equivalent standards determined by the Board.

(b) Rejections of applications will include evaluation reports and instructions for completing requirements.

(c) The order upon which a Candidate completes education and/or training may, at the sole discretion of the Board, be considered to have met or not met their requirements.

55:10-5-5. Landscape Architect and Interior Designer application deadlines

Applications for an initial License to practice landscape architecture ~~registration~~ may be made at any time, ~~but, if Landscape Architect applications received later than March 1st for the June exams or October 1st for the December exams, they will be continued to the next examination schedule.~~ Interior Design applications for initial Registration as an Interior Designer received later than March 1st for the fall exams or October 1st for the spring exams will be continued to the next examination schedule. All applications, fees and notifications must reach this office by 4:30 p.m. on the due date and postmarks will not be accepted.

55:10-5-6. Active and inactive applications

Applications for examination will remain effective for six years only. Incomplete applications are withdrawn after one (1) year and the Applicant will be required to reapply. Applications for examination for current Architect or Landscape Architect Candidates testing on the six (6) year time period shall remain active for the six (6) years examination period only. At the end of the six (6) year period, these Candidates shall reapply as a new Candidate and begin testing under the five (5) year rolling clock. Candidates testing on the five (5) year rolling clock shall remain active for five (5) years after the last examination section was passed. Interior Design Candidates shall remain active for five (5) years after the last examination was taken. Incomplete applications are withdrawn after one (1) year and the Applicant will be required to reapply. Applicants and Candidates called to active military duty in the armed forces of the United States and deployed to a temporary military assignment, shall be exempt from the retention period

for the duration of the temporary deployment under Section 55:10-7-1.

55:10-5-7. Qualifications for an Architect registration License

(a) An Applicant for an initial registration as an Architect License to practice architecture in Oklahoma shall be a person an individual of good moral character and not less than 21 years of age. Further, the Applicant shall have a professional degree from an NAAB accredited program in a school of architecture or an equivalent degree and provide evidence of acceptable training in architecture as noted in Section 55:10-5-4, in the current "NCARB Handbook for Interns and Architects" and "NCARB Education Standard" and "Intern Development Program Guidelines," as adopted by the Board. The Board requires three (3) years of acceptable training and completion of the IDP program prior to licensing.

(b) The Board may, in its discretion, accept applications for an initial registration License to practice architecture from persons Applicants who are not graduates as required in Section 55:10-5-4, otherwise qualifying, who furnishes evidence acceptable to the Board of having completed an equivalent educational and training program. NCARB's current education requirements as set forth in "NCARB Education Standard," as adopted by the Board.

(c) All Applicants shall take and pass an examination on the Act and these Chapter 10 Rules, as well as pass NCARB's examination prior to receiving a License in the State.

55:10-5-8. Qualification for a Landscape Architect state registration License

(a) **General requirements.** An Applicant for an initial registration as a Landscape Architect License to practice landscape architecture shall be a person an individual of good moral character and not less than 21 years of age.

(b) **Education and training requirements.** Applicants shall have a professional degree from a LAAB accredited program in a school of landscape architecture or an equivalent educational program and provide evidence of three (3) years of acceptable training credits as provided in Section 55:10-5-4 (e) of this Section prior to licensing.

(c) **Training credits.**

(1) Training credits may not be counted prior to completion of the third year of college or a pre-professional degree. Thirty-two (32) semester credit hours or forty-eight (48) quarter credit hours are considered to be one (1) year. Fractions of one-half or greater will be considered one-half year and smaller fractions will not be counted. To earn full training credits, an Applicant must work at least 35 hours per week. A Candidate may earn one-half the credit specified for work of at least twenty (20) hours per week.

(2) Training credits are defined as follows:

(A) Diversified landscape architectural experience under the responsible control Direct Supervision and Responsible Control of a licensed Landscape Architect.

(i) 100% credit

(ii) No limit to credit

(B) Diversified landscape architectural experience under the responsible control Direct Supervision and Responsible Control of a licensed Architect or engineer.

(i) 75% credit

(ii) No limit to credit

(C) Landscape architectural experience directly related to on site construction, maintenance, or installation operations.

(i) 50% credit

(ii) 1 year maximum credit

(d) All Applicants shall take and pass an examination on the Act and these Rules as well as an examination on Oklahoma plant materials and CLARB's examination prior to receiving a license License in the State.

55:10-5-9. Reciprocal licensing and changing base or resident state registration

(a) All individuals applying for reciprocal licensing shall submit an application for the license requested and enclose the necessary fees applicable in 55:10-3-13, payable by cashier's check, money order, credit card or certified funds when submitted. Prior to being issued a license, Applicants shall take and pass an examination on the Act and these Rules. The Secretary Treasurer shall have the power at his/her discretion, to approve all reciprocal licensing that meet the statutory requirements of the Act and the Board's applicable rules in this Chapter without full Board action. The Certificate of Registration will follow at a later date.

(b) A license certificate shall be issued and will authorize him or her to engage in the practice of architecture or landscape architecture and use the title Architect or Landscape Architect in this state until the 30th day of June of the biennial license period. No license shall be issued or renewed for longer than two (2) years.

(c) Any reciprocal license denied, suspended, revoked or refused to renew, any state of the Registrant, or certification is withdrawn by NCARB or CLARB shall be cause to suspend, revoke or refusal by this Board to renew the reciprocal license in Oklahoma.

(d) The Registrant may change the base or resident state to Oklahoma by applying for a transfer of the person's official records to this Board and paying all applicable fees in 55:10-3-13.

(e) Applications for architectural registration by reciprocity shall comply with (a) of this Section and be through NCARB or directly through the Board and only to those individuals whose states have similar requirements and extend the same privilege to this state's Applicants. A letter confirming the Board's action and assignment of a registration number will be issued.

(f) Applications for landscape architectural registration by reciprocity will be through submission of a CLARB record or directly through the Board, complying with (a) of this Section and showing registration by the UNE or the LARE in any other state, country or territory whose requirements for licensing are at least equivalent to the requirements of this state and extend

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the same privilege of reciprocity to Landscape Architects registered in this state. The Applicant shall be required to submit to and pass an examination on Oklahoma plant material and an examination covering the Act and these Rules.

(g) Rejections of applications for registration by reciprocity will be by letter explaining the reasons, and outlining procedures under which reconsideration may be possible.

55:10-5-10. Qualifications for Registration as an Interior Designer

(a) **General requirements.** All individuals applying for Registration as an Interior Designer shall:

- (1) Obtain all required education and training prior to Registration.
- (2) Hold an accredited professional degree in interior design accredited by the Council of Interior Design Accreditation or its successor, obtain two (2) years or 3,520 hours of acceptable training as defined by this Subsection and pass the examinations for Registration as an Interior Designer administered by NCIDQ or its successor; or
- (3) Obtain an equivalent education to an accredited professional degree in interior design, as determined by the Board, obtain two (2) years or 3,520 hours of acceptable training and experience hours as defined by this Subsection and pass the examinations for Registration as an Interior Designer administered by NCIDQ or its successor; or
- (4) Have been issued a valid Registration from another state, jurisdiction or foreign country provided the requirements for Registration are equivalent to the requirements of this state as determined by the Board; or
- (5) Have a degree from a program accredited by CIDA or its successor. An applicant, who has completed the program within two (2) years of the program acquiring this accreditation, shall be considered to have obtained an accredited education program in interior design.

(b) **Equivalent education and defining training requirements.** The following education, training and experience may be considered to be equivalent to the requirements of OAC 55:10-5-9 as determined by the Board in its sole discretion:

- (1) A baccalaureate degree in programs of no less than 120 semester or 180 quarter passing credit hours of which 60 semester or 90 quarter hours, respectively, are interior design-related; and a total of no less than 3,520 hours of interior design acceptable training as defined herein;
- (2) Certificate, degree or diploma with a minimum passing credit of 60 semester hours or 90 quarter passing credit hours respectively in interior design related coursework and obtain 5,280 hours of acceptable training; or
- (3) Meet the educational standards set forth by the National Association of the Schools of Art and Design and other similar institutions provided the educational program has a minimum of 40 semester passing credit hours or 60 passing quarter credit hours in Interior Design related coursework and 7,040 hours of acceptable training.
- (4) Thirty (30) passing semester hours from a Board approved program shall equal one (1) year of education

towards the first accredited professional degree in interior design or its equivalent program.

(5) One (1) year of education credit hours from a Board approved program earned in an interior design program or its equivalent degree program shall equal two (2) years of acceptable training and experience.

(6) Four (4) years from a Board approved program shall be an equivalent standard for the first professional degree in interior design or its equivalent when computing the fifteen (15) years experience and training to equate towards the training and experience requirement in O.S. 59, Sections 46.39 through 46.40 of the Act.

(7) A second accredited professional degree in interior design or its equivalent shall count as one year of education for two (2) years of training and experience.

(8) Beginning July 1, 2007 through June 30, 2009, the Board may accept, in lieu of the requirement of any professional interior design degree, six (6) years of diversified and appropriate experience in interior design as defined by the Act and these Rules and has passed the examination of NCIDQ; or

(9) The Applicant is a licensed Architect. This exemption ends June 30, 2009.

(c) **Education content requirements.** Educational instruction shall include, but is not limited to, the following:

- (1) Building and Interior Systems
- (2) Business and Professional Practices, Management and Ethics
- (3) Codes and Ordinances
- (4) Basic and Creative Arts
- (5) Color Theory
- (6) Interior Design
- (7) Technical Knowledge
- (8) History and theory of Art, Architecture and Design
- (9) Human Factors
- (10) Lighting
- (11) Materials and Finishes
- (12) Communication Skills
- (13) Furnishings

(d) **Training and experience categories.** Training and experience credits shall be awarded for work performed in the following areas:

- (1) Programming
- (2) Schematic Design
- (3) Design Development
- (4) Contract Documents
- (5) Contract Administration
- (6) Professional Practice

(e) **Training and experience requirements.** The Board may accept as evidence of diversified training and experience in interior design as stated in this Subsection:

- (1) Applicants having obtained the first CIDA professional accredited degree in interior design or its equivalent shall have 2 years of acceptable training and experience hours. One year shall equal 1760 hours of training and experience. One (1) hour of full time work will equal one (1) hour of credit.

(2) Applicants may earn one (1) year of training and experience hours after completing 96 semester passing credit hours toward the first professional degree in interior design.

(3) On January 1, 2007, all individuals beginning their training and experience shall obtain credits after all educational requirements have been met for those individuals with equivalent education equating to the first accredited professional degree in interior design.

(4) Applicants with acceptable education and experience may take the examination to become an Interior Designer, regardless of the order in which each was obtained when training and experience requirements are met and if training began prior to January 1, 2007.

(5) Training and experience hours shall be awarded based on working full time for thirty-five (35) hours per week or more in interior design or architecture. Part time training and experience hours shall be calculated at the rate of fifty percent (50%) for less than thirty-five (35) hours per week and more than twenty (20) hours per week. Working less than twenty (20) hours per week will not qualify for training and experience hours. Two (2) years of full time acceptable training and experience under an Interior Designer or Architect offering services as interior design shall equal one (1) year of equivalent education in interior design.

(6) Applicants beginning their training and experience after January 1, 2008, shall be under the Direct Supervision and Responsible Control of a registered or licensed Interior Designer or a licensed Architect offering service as interior design. If the Interior Designer is not registered or licensed in a jurisdiction, then all work shall be under the Direct Supervision of an NCIDQ certificate holder.

(7) The Board, in its sole discretion, shall determine whether all education, training and experience for Applicants are acceptable or not and whether or not it satisfies the requirements for Registration.

(8) Applicants obtaining full time training and experience hours obtained in a related field with a registered or licensed Interior Designer or a Licensed Architect offering services as interior design, shall be calculated at the rate of fifty percent (50%) and shall be limited to six (6) months of the total training and experience hours required by the Board until December 31, 2007 at midnight, when this category ceases. If the Interior Designer is not registered or licensed in a jurisdiction, then all work shall be under the Direct Supervision of an NCIDQ certificate holder.

(9) Training and experience hours shall be submitted on the Board's forms or equivalent. It is the responsibility of the Applicant to obtain all required signatures. All Board forms are to be returned directly to the Board office by the employer, as they are confidential records.

(f) **Grandfather requirements.** Any Applicant who submits a properly completed and acceptable application for Registration and pays all applicable fees between July 1, 2007 and June 30, 2009 shall be issued a Certificate of Registration provided the requirements below have been met:

(1) An Applicant has submitted evidence of education and training the Board deems equivalent to an accredited professional degree in interior design, satisfied training requirements, if applicable and has passed the examinations administered by NCIDQ or its successor; or

(2) The Applicant has submitted evidence of six (6) years of diversified and acceptable training and experience hours prior to July 1, 2009, and the Board has determined and accepted such evidence as meeting these requirements and has passed the examinations administered by NCIDQ or its successor; or

(3) The Applicant is a licensed Architect.

(4) Without limitation to application deadlines, an Applicant may apply who has obtained fifteen (15) years of diversified and acceptable training and experience in the practice of interior design as determined by the Board prior to July 1, 2007, and the Applicant is not registered under this Act and not exempt from the requirements for Registration in order to use the title "Interior Designer" and provide services as interior design. The Applicant shall be exempt from passing the NCIDQ examinations and fulfilling any additional education or training requirements as determined by the Board. The Applicant may use any combination of education, training and experience as acceptable and determined by the Board to equate to the fifteen (15) years experience. Thirty (30) passing education hours equals one (1) education credit year used toward obtaining the first accredited professional degree in interior design or an equivalent degree as determined by the Board or may equal two (2) years of diversified and appropriate experience when calculating the required fifteen (15) years experience. Additionally, the Applicant obtaining a second accredited professional degree in interior design or an equivalent degree as determined by the Board may use this education in addition to other education or training.

(g) **Exemption from Registration.** An individual holding a current Architect License is exempt from Registration to offer services as interior design, describe services and has the right to use the term interior design. In order to be eligible to use the term Interior Designer, the Architect shall obtain Registration, but shall be exempt from education, training and testing requirements for Interior Designers through June 30, 2009.

55:10-5-11. Changing resident state and applying for a Reciprocal License or Registration

(a) All individuals applying for a reciprocal License or Registration shall satisfy the requirements contained in the Act and these Rules and submit an acceptable and complete application for the License or Registration requested and enclose the necessary fees payable by cashier's check, money order, credit card, if applicable or certified funds when submitted. Prior to being issued a License or Registration, Applicants shall take and pass an examination on the Act and these Rules. The Secretary-Treasurer shall have the power at his/her discretion, to approve all reciprocal applications that meet the statutory requirements of the Act and Rules in this Chapter without full

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Board action. The License or Certificate of Registration will follow at a later date.

(b) A License certificate shall be issued and will authorize the individual to engage in the practice of architecture or landscape architecture and use the title Architect or Landscape Architect in this state until the 30th day of June of the biennial License period. A Certificate of Registration shall be issued and will authorize the individual to use the title Interior Designer or offer services as interior design until the 30th day of June of the biennial Registration period. No License or Certificate of Registration shall be issued for longer than two (2) years.

(c) Any reciprocal License or Registration which is denied, suspended, revoked or refused to be renewed, by any state in which the Licensee or Registrant has obtained a License or Registration, or in which a certification is withdrawn by NCARB, CLARB or NCIDQ shall be cause to suspend, revoke or refuse to renew the License or Registration by this Board.

(d) The Licensee or Registrant may change the resident state to Oklahoma by qualifying and applying for a transfer of the individual's official records to this Board and paying all applicable fees in 55:10-3-13.

(e) Applications for an architectural License by reciprocity shall comply with (a) of this Section and be through NCARB or directly through the Board and only to those individuals whose states have similar requirements and equivalent standards and extend the same privilege to this state's Applicants. Upon approval, a letter confirming the individual's qualifications will be sent and the Board will assign a License number.

(f) Applications for a Landscape Architect License by reciprocity will be through submission of a CLARB record or directly through the Board, complying with (a) of this Section and showing licensure by the UNE or the LARE in any other state, country or territory whose requirements for licensing are at least equivalent to the requirements of this state and extend the same privilege of reciprocity to Landscape Architects licensed in this state. The Applicant shall be required to pass an examination on Oklahoma plant material. Upon approval, a letter confirming the individual's qualifications will be sent and the Board will assign a License number.

(g) Applications for an Interior Design Registration by reciprocity shall comply with (a) of this section through submission of an NCIDQ record or directly through the Board and only to those individuals whose states have similar requirements and equivalent standards and extend the same privilege to this state's Registrants. Upon approval, a letter confirming the individual's qualifications will be sent and the Board will assign a Registration number.

(h) Rejections of applications for a License or Registration by reciprocity will be by letter explaining the reasons, and outlining procedures under which reconsideration may be possible.

SUBCHAPTER 7. EXAMINATION

55:10-7-1. Examination required for Candidates

(a) Approved Candidates for initial registration—Architect and Landscape Architect licensing shall personally—individually appear and pass the required examinations.—that will be

~~conducted under conditions warranting honest and best results. Candidates can may take any section of the examinations that has not been previously passed. After June 30, 1999, All current Candidates shall have a six (6) year time frame to pass all sections of the examination. Any Candidate failing to obtain a passing score on all sections of the examinations within the six (6) year period, shall forfeit all credits for any all section(s) of the examinations previously passed. These Candidates shall re-apply as a new Candidate after their six (6) year testing period ends and begin testing under the new five (5) year rolling clock.—Board members and/or their representatives will monitor all tests, and Candidates will not be permitted to communicate with one another during examination periods.~~

(b) Beginning July 1, 2007, all new Candidates for licensing as Architects and Landscape Architects shall begin on a five (5) year rolling clock. The clock begins from the date the Candidate passes the first section. The passing grade for any section shall be valid for five (5) years only, after which time the section shall be retaken if the remaining sections have not been passed within the five (5) year period. If a Candidate fails to pass all remaining sections within the initial five (5) year period, the Candidate is given a new five (5) year period from the date of the second oldest passed section and so on. After passage of all sections of the examinations within five (5) years, and prior to licensing, all Candidates shall take and pass an examination on the Act and these Rules. In addition, Landscape Architect Candidates shall take and pass an examination on Oklahoma plant materials prior to licensing.

(c) Candidates for Registration as Interior Designers shall be required to take and pass the NCIDQ examination on interior design, unless exempt by the Act. Candidates shall submit a properly completed and acceptable application, documentation and applicable fees to the Board. Evaluation and determination of qualifications prior to beginning testing shall be determined by the Board in its discretion according to current NCIDQ standards, the Act and these Rules. Upon approval by the Secretary-Treasurer of the Board or by the Board, NCIDQ and the Candidate shall be notified of the Board's decision for entrance into the examination. Upon completing the examination, the Candidate shall contact NCIDQ and have them send a letter to the Board indicating the Candidate has passed the entire examination. Prior to Registration, the Candidate shall take and pass an examination on the Act and these Rules. Upon payment of the Registration fee and properly completed and acceptable updating of the application, the Board may issue the Registration.

(d) Any Candidate on active military duty deployed to a temporary military assignment, shall be exempt from the retention period for the duration of the temporary deployment. In order to qualify for this exemption, the Candidate shall submit military documentation of the deployment to the Board office and the staff shall place the Candidate on military active status. Upon return from the temporary military deployment, the Candidate shall submit to the Board office within thirty (90) days, military documentation that the individual has returned from deployment. The Candidate shall then be returned to regular active status for examination without losing any credits for sections passed.

55:10-7-2. Examination notifications

Examination information, formats, dates, times and places will be announced in notices mailed to Landscape Architect Candidates, at their last known address. NCARB or NCIDQ will notify all Candidates of all pertinent examination information at the Candidate's last known address.

55:10-7-3. Examination

Examinations offered ~~by the Board will may~~ be developed by NCARB, ~~and CLARB or NCIDQ~~, developed ~~by that organization's examination committee and as approved~~ for administration on specified dates. Landscape Architect Candidates and reciprocal Applicants shall, in addition to other CLARB testing materials, be tested upon their knowledge of Oklahoma plant material. All Applicants shall, after completing all other required examinations, take and pass an examination on the Act and these Rules prior to being licensed or registered in the state.

55:10-7-5. Examination fee refunds

The Board may return examination fees paid to the Board by an Applicant whose application to take the examination has been rejected or for other extenuating circumstances approved by the Board. No refund of the examination application fee shall be returned to any Applicant who takes any section of the examination or who voluntarily withdraws after his/her application to take the examination has been approved.

55:10-7-6. Grading

Exams will be graded and scored generally in accordance with NCARB, ~~and CLARB or NCIDQ~~ procedures except as directed by the Board. Minimum passing scores are adopted as recommended by NCARB, ~~and CLARB or NCIDQ~~. Minimum passing scores on the landscape architectural plant material and the Act and Rules examination shall be 75%. Examination Candidates will pass or fail in accordance with the current NCARB, ~~and CLARB or NCIDQ~~ grading procedures.

55:10-7-7. Reexamination

(a) Prior to June 30, 1999, the Board may shall allow unlimited opportunities to retake the architectural and landscape architectural examinations previously failed according to Section 55:10-7-1. After June 30, 1999, all currently testing Architect and Landscape Candidates shall have a six (6) years from the first sitting for the examination to pass all sections of the examination. Any Candidate failing to obtain a passing score on all sections of the examination within the six (6) year period shall forfeit all credits for any section(s) of the examination previously passed. Candidates failing to appear for reexamination within a the six (6) year period will shall forfeit any credits all section(s) of the examinations previously passed for parts passed, and are required to shall re-apply for admission to the examinations, as a new Candidate, except for those Candidates on temporary military deployment, who are exempt under 55:10-7-1. This consists of filing a new updated

application and paying the fees which may be processed by the Board's staff without Board approval.

(b) Beginning July 1, 2007, all new Candidates for licensing as Architects and Landscape Architects shall begin on the five (5) year rolling clock, as described in 55:10-7-1 and shall continue to retest under those provisions until the entire sections of the examinations have been passed within the five (5) year period. If a Candidate fails to pass all remaining sections within the initial five (5) year period, the Candidate is given a new five (5) year period from the date of the second oldest passed section and so on. No passing score is valid for longer than five (5) years. New Candidates failing to appear for re-examination within the five (5) year rolling clock and allowing all grades to expire over five (5) years old, shall forfeit all credits for parts passed and are required to reapply for admission to the examinations, except for those Candidates on temporary military deployment, who are exempt under 55:10-7-1. Interior Design Candidates shall be permitted to retest according to the guidelines of NCIDQ.

55:10-7-8. Review of examination grades; retention period

(a) The Board will not review any sections of the examinations.

(b) ~~Examination answer sheets and graphic sections will be kept in the Board office for three (3) years.~~ The Board will retain the final valid test scores on individual sections of the examinations taken and passed for Architect, Landscape Architect or Interior Design Candidates as determined by 55:10-7-1, for six years following the date the Candidate completes first sits for the examination. Final passing scores will be placed in the Candidate's Registrant's file and retained permanently.

(c) Candidates called to active military duty in the armed forces of the United States and deployed to a temporary military assignment, shall be exempt from the retention period for the duration of the temporary deployment as in Section 55:10-7-1.

55:10-7-9. Transfers of examination grades prior to licensing

(a) **Outgoing transfers.** The Board staff, upon written request, by the Candidate and payment of the file transfer fee, will transfer final or valid examination grades given under the Board's jurisdiction to any other duly constituted architectural or landscape architectural Architect, Landscape Architect or Interior Design registration boards and to NCARB, CLARB or NCIDQ and NCARB for use in evaluating such Applicant's eligibility for licensing or Registration, certification as applicable. A transfer to another board shall immediately terminate the Applicant's application with this Board.

(b) **Incoming transfers.** The Board will not accept, toward obtaining an initial License or Registration, scores on separate test sections taken in other states by Candidates who did not meet Oklahoma requirements for admission to the exams at the time the exams were taken.

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SUBCHAPTER 9. LICENSING AND REGISTRATION

55:10-9-1. The License or Certificate of Registration

A License or Certificate of Registration shall be issued to individuals meeting all requirements of the Act and the Rules of the Board. Such License or Certificate of Registration shall identify the individual Registrant by name, ~~and License or Registration number~~, designate an effective date, confirm the individual's Registrant's qualifications and acknowledge the individual's Registrant's right to practice architecture, ~~or landscape architecture or offer services as interior design or use the titles Architect, Landscape Architect, Interior Designer or other restricted titles defined by the Act or the Rules as the case may be, in the state.~~ Every Architect certified by NCARB, but unlicensed in the state, shall apply to the Board for licensing within ten (10) working days after notification of selection (whether notified orally or in writing) as the Architect by the client/owner. Such Architect shall be licensed in the state prior to signing a contract or engaging in the practice of architecture, as defined by the Act.

55:10-9-2. Term of License or Certificate of Registration

A License or Certificate of Registration will be issued by the Board for the life of the individual Registrant, subject to ~~the registrant~~ meeting all requirements of renewal, meeting continuing education requirements where required, and subject to the Board's powers of reinstatement, fining, probation, suspension, revocation, penalties, orders or refusal to renew for cause, vested in the Board by the Act.

55:10-9-3. Required display of the License certificate of registration

Each ~~person~~ individual holding a certificate of registration License shall display it at his/her place of practice and is prepared to substantiate biennial ~~registration renewal~~ renewals.

55:10-9-4. Duplicate certificates License or Registration

~~Duplicate~~ A duplicate License or Certificates of Registration will ~~may~~ be issued to an individual Registrant provided:

- (1) the current License or Registration renewal is effective;
- (2) ~~the Registrant makes a~~ written request for a replacement or duplicate certificate License or Registration is received; and
- (3) ~~the Registrant the fee is paid as pays the fee prescribed in 55:10-3-13.~~

55:10-9-5. Suspension, revocation, or refused renewal of a License or Certificate of Registration

(a) Surrender of License or Certificates of Registration. Upon notice of the Board, Licenses or Certificates of Registrations suspended, revoked or refused by the Board to ~~renew~~ be renewed for cause, as defined in (b) of this Section, shall be surrendered immediately in the manner prescribed by that notice.

(b) Cause defined. Cause shall be defined as any violation of the Act and the Board's current Rules in this Chapter. Cause shall also be defined as another state refusing to renew the Architect's, ~~or Landscape Architect's License or Interior Designer's Registration, professional license,~~ not meeting continuing education requirements, if applicable, suspension or revocation of a License or Registration or NCARB, and CLARB or NCIDQ withdrawing the certification of the individual Licensee or Registrant.

55:10-9-6. Biennial License or Registration required

(a) The Act requires all Architects, ~~and Landscape Architects and Interior Designers~~ desiring to practice or use the professional titles in Oklahoma to biennially renew the License or Registration register with the Board and pay a biennial License or Registration renewal fee in 55:10-3-13. Notices will be sent to all Licenseses and Registrants at the last known address of record; however, it is the responsibility of each individual Licensee or Registrant to insure the renewal fees and applications are received by the Board office, properly completed and acceptable on or before 4:30 p.m. on June 30th of the renewal year to avoid penalties. Upon receipt by the Board of the individual's and if applicable, Entity's renewal forms, continuing education forms if applicable, fees and compliance with the Board's current ~~rules Act and Rules~~ in this Chapter, the License or Registration shall be renewed. No License or Registration will be issued for longer than a 2 (two) year period.

(b) Licenseses or Registrants called to active military duty in the armed forces of the United States and deployed to a temporary military deployment shall comply with OAC 55:10-3-13.

55:10-9-7. Emeritus status requirements

Licenseses and Registrants, who are residents of Oklahoma, ~~and~~ who have been licensed or registered in this state for ten (10) consecutive years, sixty-five (65) years of age or older and retired from active practice, providing services as interior design or other related professional activities, may request emeritus status by filing the application showing compliance with this Section. If the Rules of this Chapter have been met, all fees and penalties for biennial License or Registration shall be waived by the Board. Emeritus status Licenseses are also exempt from continuing education requirements unless they ~~reactivate/reinstate~~ their License or Registration to active status in accordance with OAC 55:10-9-9. At that time, they shall complete the continuing education requirements for the current licensing period.

55:10-9-8. Failure to register biennially renew

(a) Failure to biennially register-renew the License or Registration and satisfy all continuing education requirements, if applicable, and remit renewal fees, submit properly completed and acceptable forms with pertinent information and pay penalties where applicable in 55:10-3-13, as prescribed by the Act and the Board's current Rules in this Chapter, will result in automatic suspension and revocation of the License, Registrant's Certificate of Registration, and the Certificate of Authority and/or Certificate of Title on July 1st of the renewal year.

(b) Notices of automatic suspension and/or revocation will be sent to the last known address of the Licensee, Registrant or Entity. If a License, Registration, Certificate of Authority or Certificate of Title is not renewed for any reason, the Licensee or Registrant must immediately cease the practice of architecture, landscape architecture or offering services as interior design. An Architect, Landscape Architect or Interior Designer shall cease using these professional titles or other titles restricted by the Act or the Rules. Individuals who continue to practice architecture, landscape architecture or offering services as interior design during the time of suspension and/or revocation are subject to the fines, penalties and civil remedies contained in the Act and these Rules.

**55:10-9-9. Emeritus readmission to active practice
Reinstating License and Registration
from emeritus status to active practice**

(a) Reinstatement within five years. Emeritus persons may be readmitted to the active practice of their respective professions without reexamination upon proper application within five (5) years of acquiring emeritus status. Continuing education requirements shall be met for the current licensing period only.

(b) Reinstatement after five years. An emeritus Licensee who has enjoyed emeritus status in excess of five (5) consecutive years may be readmitted to active practice of the profession as defined by the Act.

(c) Fees required. An emeritus Licensee seeking readmission to active practice shall pay all applicable fees in 55:10-3-13, not to exceed the current License fees for a two (2) year period and shall be required to meet continuing education requirements for the current licensing two (2) year period. No CEU reinstatement penalties shall apply while the person was in emeritus status. An individual desiring to reinstate a License or Registration to an active status may do so by re-applying and paying a readmission application fee. The Board has full discretion as to how to reinstate the License or Registration or determine not to reinstate the License or Registration. If the Board, in its sole discretion reinstates the License or Registration, the individual shall pay the current License or Registration fee in 55:10-3-13. The individual shall also complete the continuing education requirements, if applicable, for the current License or Registration period and comply with all other Board requirements.

55:10-9-10. Reinstatement of canceled License or Registration

(a) Reinstatement for nonpayment of fees and/or failure to comply with continuing education requirements within three years of cancellation of License.

(a) **Reinstatement of any License or Registration within three (3) years.** Licenses or Registrations canceled for nonpayment of fees and/or failure to comply with continuing education requirements if applicable, may be renewed at any time within three (3) years, from the date of the cancellation, upon compliance with the Act and the Board's current Rules and upon paying payment to the Board all the fees which shall have been accrued at the time of the cancellation and which would have been paid at the time of reinstatement had not the License or Registration been suspended and revoked, together with the amount of penalties prescribed in 55:10-3-13. Additionally, no License or Registration shall be reinstated unless the person-individual has completed all past continuing education requirements, where applicable for the three (3) years and paid to the Board the penalties for reinstatement set forth in OAC 55:10-3-13. These Licenses and Registrations may be reinstated by the Board's staff upon compliance with the Act and Rules of the Board without Board action.

(b) Reinstatement for nonpayment of fees and/or failure to comply with continuing education requirements three years after cancellation of license. For those Architects or Landscape Architects licensed initially in Oklahoma, if a registration canceled for nonpayment remains canceled for a period exceeding three consecutive years, such former Licensee shall have a license reinstated in a manner consistent with the Act.

(b) **Reinstatement of initial License or Registration after three (3) years.** For those Architects, Landscape Architects or Interior Designers licensed or registered initially in Oklahoma that allow their License or Registration to remain cancelled for a period exceeding three (3) consecutive years, such former Licensee or Registrant may have the License or Registration reinstated in a manner as determined by the Board consistent with the Act and these Rules, after reapplying and paying a readmission application fee. Additionally, the Licensee or Registrant shall meet all continuing education requirements where applicable, that would have been otherwise required, and pay all back fees and penalties.

(c) Reinstatement of Reciprocal Licenses or Registrations after three (3) years. Any Architect or Landscape Architect licensed to practice in Oklahoma by reciprocity must, after his/her reciprocal License has been canceled for nonpayment for more than three (3) years, re-apply through the means of which the initial License was granted or demonstrate a current License in another jurisdiction, meet all continuing education where applicable that would have been required, and pay a readmission application fee and all back fees and penalties. Interior Designers must re-apply and prove a current Registration in another jurisdiction or through NCIDQ, pay a readmission application fee and pay all back fees and penalties.

(d) Reinstatement of Licenses based on cause. Registrations suspended, refused to renew, penalties, orders issued or revoked for cause, may be reinstated only by Board action and

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only then in the manner determined by such Board action. Request for reinstatement of registration may be filed after all appeals have been exhausted and the further passage of six (6) months of suspension, refusal to renew, penalties, orders issued or revoked for cause. The request shall show the Board that the public interest will not suffer by reason of the reinstatement and should be addressed to the Secretary-Treasurer at the Board office. The Board by law, has the discretion as to whether to reinstate the License, Certificate of Authority or deny it.

(d) Returning from temporary military deployment. Licensees or Registrants returning from temporary military deployment shall notify the Board office consistent with OAC 55:10-3-13(b).

55:10-9-11. Reinstatement of a License or Registration based on cause

A License or Registration suspended, refused to be renewed, penalties levied, orders issued or revoked for cause, may be reinstated only by Board action and only then in the manner determined by the Board. Request for reinstatement may be filed by re-applying, paying a readmission application fee after all appeals have been exhausted and the further passage of six (6). The request shall show the Board that the public interest will not suffer by reason of the reinstatement and should be addressed to the Secretary-Treasurer at the Board office. The Board has the sole discretion as to whether to reinstate the License or Registration, deny the reinstatement and require the payment of all back fees, penalties and meet continuing education requirements if applicable.

SUBCHAPTER 11. RULES OF PROFESSIONAL CONDUCT

55:10-11-1. General requirements

A Licensee Registrant—or Entity shall above all, serve and promote the public interest in the effort to improve the human environment and shall act in a manner to bring honor and dignity to the professions of architecture and landscape architecture.

55:10-11-2. Good moral character

The Act requires all Registrants-Licensees to be of good moral character. Among items considered as defining the lack of good moral character are:

- (1) Practicing architecture or landscape architecture without a License in violation of any jurisdiction regulation.
- (2) Conviction of a felony.
- (3) Misrepresentations or falsifications of fact in an application for licensing or any other document filed with the Board.
- (4) Individual cases may require consideration of other items that define the lack of good moral character.

55:10-11-3. Competence

(a) In engaging in the practice of architecture or landscape architecture, a Licensee Registrant—or Entity shall act with care and competence, and shall apply the technical and tactical knowledge and skill which is ordinarily applied by licensed Architects and Landscape Architects of good standing. The Licensee Registrant—or Entity shall not directly or indirectly indulge in exaggerated, misleading, deceptive or false statements or claims about professional qualifications.

(b) In designing a project, a licensed Architect or Landscape Architect shall follow all applicable state and municipal building laws, codes and regulations. While a Licensee Registrant of these professions may rely on the advice of other professions as to the intent and meaning of such laws, codes and regulations, once having obtained such advice, the Licensee Registrant—shall not intentionally or negligently design a project in violation of such laws, codes and regulations. When two or more codes are in conflict, the standard of practice is to use the most restrictive.

(c) A licensed Architect or Landscape Architect shall undertake to perform professional services only when he or she together with those engaged as consultants, is qualified by licensing, education, training and experience in the specific technical and tactical areas required. The Licensee Registrant shall establish by agreement, the nature and extent of services to be provided and the compensation to be paid.

(d) No individual shall be permitted to engage in the practice of architecture or landscape architecture if, after a hearing, in the Board's judgment, such individual's professional competence is found to be substantially impaired by mental disabilities. An individual may apply for reinstatement through the procedures established by the Rules in this Chapter.

55:10-11-4. Conflict of interest

(a) A Licensee Registrant—or Entity shall not accept or receive compensation directly or indirectly for services from any person-individual or Entity other than the client in connection with the reparation, alteration or construction of a project in relation to which the Licensee Registrant—or Entity shall have accepted employment in any manner.

(b) If a Licensee Registrant—or Entity has any business association or direct or indirect financial interest in a project undertaken to perform professional services, the Licensee Registrant—or Entity shall fully disclose in writing to the client or employer the nature of the business association or financial interest, and, if the client or employer objects to such association or financial interest, the Licensee Registrant—or Entity shall either terminate such association or interest or offer to give up the commission or employment.

(c) A Licensee Registrant—or Entity shall not solicit or accept compensation from material or equipment suppliers in return for specifying or endorsing their products.

(d) A Licensee Registrant—or Entity shall not publicly endorse a product, system, or service, or permit the use of his/her or its name or photograph to imply such endorsement. However, he/she or it may be identified with any product, system, or service designed or developed by him/her or it.

(e) When acting as the interpreter of building contract documents and the judge of contract performance, a Licensee Registrant or Entity shall render decisions impartially, favoring neither party to the contract.

55:10-11-5. Full disclosure

(a) A Licensee Registrant or Entity making public statements on architectural or landscape architectural questions, shall disclose when he/she or it is being compensated for making such statements.

(b) A Licensee Registrant or Entity shall accurately represent to a prospective or existing client or employer his/her/its qualifications and the scope of responsibility in connection with work for which he/she/it is claiming credit. ~~A person~~ An individual leaving employment shall obtain written permission from the employer to take or copy plans and specifications when they leave the Entity.

(c) If, in the course of his/her/its work on a project, the Licensee Registrant or Entity becomes aware of a decision taken by his/her/its employer or client, against such Licensee's Registrant's or Entity's advice, which violates applicable state or municipal building laws, codes or regulations, and which will, in the Licensee's Registrant's or Entity's judgment, materially and adversely affect the health, welfare and safety to the public of the finished project, the Licensee Registrant or Entity shall:

- (1) report the decision to the local building inspector or other public official charged with the enforcement of the applicable state or municipal building laws, codes or regulations;
- (2) refuse to consent to the decision;
- (3) in circumstances where the Licensee Registrant or Entity reasonably believes that other such decisions will be taken, notwithstanding her/his/its objection, terminate services with respect to the project. In the case of a termination in accordance with (c) of this Section, the Architect, Landscape Architect or Entity shall have no liability to his/her/its client or employer on account of such termination.

(d) A Licensee Registrant or Entity shall not deliberately make a materially false statement or fail deliberately to disclose a material fact requested in connection with an application for a License, Registration, registration, renewal or contract with a client/owner.

(e) A Licensee Registrant or Entity shall not assist the application for an individual or Entity known by the Registrant or Entity to be unqualified in respect to education, training, experience or character.

(f) ~~A Registrant or Entity possessing knowledge of a violation of the rules in this Chapter or the Act, by another Registrant or Entity, shall report such knowledge to the Board. A Licensee or Entity, shall report such knowledge to the Board.~~

(g) ~~The architect~~ Architect, landscape architect Landscape Architect or Entity contracting to provide professional services shall disclose whether or not they carry liability insurance or are bonded for the project. If insurance or a bond is canceled during the term of a contract, or any extension thereof, the client/owner shall be notified in writing of the cancellation.

55:10-11-6. Compliance with laws

(a) A Licensee Registrant or Entity shall not, while engaging in the practice of his/her/its profession, knowingly violate any state or federal criminal law.

(b) A Licensee Registrant or Entity shall neither offer nor cause to be offered any payment or gift to a government official, elected or appointed, with the intent of influencing the official's judgment in connection with a prospective or existing project in which the Licensee Registrant or Entity is interested.

(c) A Licensee Registrant or Entity shall comply with the ~~registration~~ licensing laws, and rules and/or regulations governing his/her/its professional practice in any jurisdiction.

55:10-11-7. Professional conduct

An Architect, Landscape Architect or Entity shall preserve the confidences of the client or employer. A Licensee Registrant or Entity may make contributions of service or anything of value to those endeavors which he/she/it deems worthy. A Licensee Registrant or Entity has the right to participate in the political process and to contribute time and money to political campaigns. In making political contributions, the Licensee Registrant or Entity shall do so publicly.

(1) Each office in Oklahoma maintained for the preparation of drawings, specification, reports or other professional work shall have a Licensee Registrant in that office having Direct Supervision and being in Responsible Control of such work.

(2) A Licensee Registrant shall not sign or seal drawings, specifications, reports or other professional work for which he/she does not have ~~responsible control~~ Direct Supervision and is in Responsible Control. Provided, however, that in the case of the portions of such professional work prepared by the Licensee's Registrant's licensed consultants, ~~licensed registered~~ under this or another professional license in registration of Oklahoma, the Licensee Registrant may dually sign and seal that portion of the professional work if the ~~licensed registered~~ Architect or Landscape Architect has additionally coordinated its preparation and intends to be responsible for its adequacy.

(3) A Licensee Registrant or Entity shall neither offer nor make any gifts, other than gifts of nominal value including, for example, reasonable entertainment and hospitality, with the intent of influencing the judgment of an existing or prospective client in connection with a project in which the Licensee Registrant or Entity is interested. Intent of influence means influence, direct or indirect, which induces or tends to induce consideration or action with respect to any prospective work on any basis other than the merits of the matter.

(4) A Licensee Registrant or Entity shall not engage directly or indirectly an agent or representative to solicit work on his/her/its behalf whose compensation is contingent, in whole or in part, upon obtaining professional work for the Entity, Architect or Landscape Architect.

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(5) A ~~Licensee Registrant~~ or Entity shall not make false statements about the professional work, or maliciously injure or attempt to injure the prospects, practice or employment position of others.

(6) A ~~Licensee Registrant~~ or Entity shall not furnish limited services in such a manner as to enable owners, draftsmen, or others to evade public health and safety requirements.

(7) A Licensee or Entity provides a service to the client, as well as a product and as such is only responsible for the design of the facility represented by the drawings he or she signed, sealed and dated for a specific client and location. Should the client or any other individual modify or change locations of the facility or make changes to the design without the authorization of the Licensee, the Licensee is only responsible and liable for the project as he/she signed, sealed and dated it and the site at the original location. Nothing contained herein shall apply to prototype plans, where the Licensee is allowed to review and adapt a plan already sealed by the original Licensee and the current Licensee is making changes to adapt in whole or in part to a different location and bring the plan up to the current code requirements. In this case, the Licensee is required to sign, seal and date only the changes to the original documents and shall only be responsible for his/her new changes.

55:10-11-8. ~~Registrant's Licensee's seal~~

(a) Seal required. Every ~~person-individual~~ authorized to practice architecture or landscape architecture by a ~~License certificate of registration~~ shall procure a seal with which to identify all technical submissions, addenda, field orders and other documents of service issued by the ~~Licensee Registrant~~ for use in this state. This seal may be purchased from any company of the ~~Licensee's Registrant's~~ choice or computer generated.

(b) Type of seal. The seal required shall be of a type that makes an image on the surface of original documents and duplications of original documents. The use of a rubber stamp or electronic image producing an accurate and legible image of the seal is permissible.

(c) Design of seal. The seal of a licensed Architect shall contain his/her name, Oklahoma ~~License number registration number, city, state of residence~~ and the words, "Licensed Architect, State of Oklahoma." The seal of a licensed Landscape Architect shall contain his/her name, Oklahoma ~~License number registration number~~ and the words, "Licensed Landscape Architect, State of Oklahoma." Examples of acceptable forms for the design of seals are available from the Board.

55:10-11-9. Authorized use of seal

(a) Seal declares authorship. The seal appearing on any technical submission shall be a prima facie evidence in 55:10-15-1 that said technical submission was prepared by or under the individual named on said seal. Changes made to a signed, sealed and dated end of point product or service that are not designed by the original Licensee and that are not

authorized or indicated by the seal of another Licensee on the changes, exempts the original Licensee from any authorship or liability concerning any changes made, including making site changes without the knowledge of the Licensee.

(b) Location of seal, signature and date. The seal impression or image shall be across the signature that may be generated electronically of the ~~Licensee Registrant~~ responsible to this Board for authorship of the documents thus identified. The handwritten date the signature is affixed shall accompany the signature.

(c) Use of seal is individual act. Authorized use of the prescribed seal is an individual act. The ~~Licensee Registrant~~ is responsible for its security when not in use.

(d) Use or attempted use of seal by unauthorized ~~persons-individuals~~. No ~~person-individual~~, other than the ~~Licensee Registrant~~ represented, shall use or attempt to use the prescribed seal, and no unregistered ~~person-individual~~ or Entity shall be authorized to use the prescribed seal, except as described in (c) above. Use, reproduction distribution or attempted use of the seal shall include using a set of construction documents to construct a structure on another site without the permission of the original Licensee or making unauthorized copies, changes or incorporating any portion of the specifications into another work without the use of a Licensee's seal, signature and date authorizing such changes. Prototype building plans shall carry the seal, signature and date of the original Licensee, but may be used at other locations, as an intended use.

(e) Entire Contract. Any licensed Architect or Landscape Architect preparing documents that would be considered to fulfill an entire contract with a client being the end point of service, whether or not the plans are complete, shall sign, seal and date those documents. The Licensee may add any words on the documents that he/she/it chooses to indicate an incomplete document and not for construction notice.

(f) Technical submissions. Architects and Landscape Architects are permitted to review and adapt portions of technical submissions if:

(1) the seal of the original Architect or Landscape Architect appears on the submissions to authenticate authorship.

(2) the succeeding Architect or Landscape Architect clearly identifies all modifications to the submissions.

(3) the succeeding Architect or Landscape Architect assumes responsibility and liability for the adequacy of the design on the modifications.

55:10-11-10. Required use of seal, signature and date on documents and retention period

(a) All ~~Licensees shall Registrants~~ must affix their seal, signature and date to all original working drawings, and to the original cover sheet and ~~index the page~~ identifying all specification pages covered, including all addenda and field changes.

(b) In the absence of sheets or covers identifying all sheets or pages bound, all original contract documents of service must have the seal, date and signature of the ~~Licensee Registrant~~ responsible and the date prepared affixed thereto. In addition, the ~~Licensee Registrant~~ shall identify on the ~~index page~~ or covers ~~of~~ sheets or pages bound, by name and License number, the

consultants used on the project and the sections the consultants worked on.

(c) An Architect, Landscape Architect or Entity shall retain a copy of all technical submissions produced for a minimum of fifteen (15) years following the date of preparation. Should the submissions be retained by electronic means, all submissions shall be updated into current versions so they are accessible at all times and can be printed out in a legible format.

55:10-11-11. Prohibition on submitting documents without seal, date and signature

No Architect or Landscape Architect shall submit technical submissions for a building permit or other submission without affixing his/her seal, date and signature to the work. All technical submissions shall clearly state the name of the firm, the Licensee responsible for the project Registrant and the date prepared.

55:10-11-12. Prohibited use of seal

(a) Prohibition on sealing documents. No Licensee Registrant shall affix or attempt to affix the seal, signature or date to sketches, working drawings, specifications or other documents developed by others not under the Direct Supervision and being in Responsible Control and not subject to the authority of that Licensee Registrant in critical, professional judgments, except as stated in OAC 55:10-11-9(e) and (f).

(b) Prohibited acts using seal. No Licensee Registrant shall affix the seal, signature or date to documents unless:

- (1) such documents were developed and prepared under the Licensee's Registrant's Direct Supervision and Responsible Control;
- (2) the Licensee Registrant had full authority to determine their development; and
- (3) the Licensee Registrant has reviewed and adopted, in whole or in part, architectural or landscape architectural portions and has either coordinated their preparation and integrated them into the work.

SUBCHAPTER 13. ORGANIZATIONAL PRACTICE

55:10-13-1. Individual and group practice

Individual Licensees or Registrants holding current Li- censes or Certificates of Registration may organize or engage in individual or group practice of architecture, ~~or~~ landscape architecture or organize in an Entity for the purposes of representing themselves as an Interior Designer or offering services as interior design allowed by statutes of this state and which are in compliance with the Act and the Board's current Rules in this Chapter. The Secretary-Treasurer of the Board may approve these applications without full Board action.

55:10-13-2. Licensee required in each office

Each Entity in the state where architectural or landscape architectural services are offered or performed for execution in

Oklahoma shall have a current Oklahoma ~~registered~~-licensed Architect or Landscape Architect in Direct Supervision and being in Responsible Control.

55:10-13-3. Licensees accountable individually

The responsibility of the Board to safeguard the life, health, property, and the public welfare against the irresponsible practice of the professions of architecture and landscape architecture is vested in the qualification and responsibility of Licensees Registrants who are individually accountable.

55:10-13-4. Certificate of Authority or Certificate of Title required

Excluding sole proprietorships practicing or using a title of profession under the name of the ~~Licensee~~-Architect, Landscape Architect or Interior Designer only, all entities, including entities using a fictitious name, practicing, offering to practice or contracting to provide architectural or landscape architectural services or using the title of Interior Designer or offering services as interior design in the State of Oklahoma shall file an application with the Board, pay applicable fees and penalties in OAC 55:10-3-13 and, if qualified, be issued a Certificate of Authority or Certificate of Title by the Board. Certificates of Authority or Certificates of Title may be granted by the Board to any Entity which meets the criteria of reeog- nized under the Act and is these Rules and approved by the Secretary-Treasurer of the Board, which meets the criteria in OAC 55:10-13-5.

55:10-13-5. Establishing criteria for issuance of Certificate of Authority or Certificate of Title

The Board may grant a Certificate of Authority to practice architecture or landscape architecture through individual Licensees or a Certificate of Title to represent the person as an Interior Designer or to offer services as interior design through Registrants to those firms meeting the following criteria:

- (1) An application is filed and approved by the Secre- tary-Treasurer of the Board or the Board.
- (2) At least one general partner, or director, officer, shareholder, manager, member or principal is a licensed Architect or Landscape Architect and designated as being responsible for the practice of the profession and is licensed to practice architecture or landscape archi- tecture in the State of Oklahoma or is registered as an Interior Designer offering services of interior design and responsible for the Entity. If a firm is offering multiple to practice both professions, the firm shall have at least one general partner, director, officer, shareholder, principal or for a limited liability company, a manager or member who is licensed or registered in each profession; and is design- ated as being responsible for the activities practice of the profession and licensed to practice of each profession.
- (3) The firm's practice of architecture or landscape architecture in any office (e.g. branch office) is under the Direct Supervision and being in Responsible Control of a duly-licensed Architect or Landscape Architect and such

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individual supervises its activities and is ~~duly~~-listed in the Certificate of Authority as an Architect of Record.

(4) All technical submissions, original working drawings, original cover sheet and ~~index~~ the page identifying all specification pages covered, all addenda and field changes shall be signed, sealed and dated by an Architect of Record defined in 55:10-1-3.

(5) The Certificate of Authority ~~or the Certificate of Title~~ shall identify the individual(s) Oklahoma licensed Architect(s) or Landscape Architect(s) ~~or registered Interior Designer(s)~~, who shall be an Architect of Record or an ~~Interior Designer of Record~~ and in responsible charge of the professional activities of the Entity ~~the architectural or landscape architectural practice; and~~

(6) Compliance with the Board's Rules in this Chapter and the Act shall not alleviate other members, officers, shareholders, managers, principals, directors, partners or employees from direct responsibility and liability by reason of employment or relationship with the Entity to the Board.

(7) The Certificate of Authority ~~or Certificate of Title~~ issued by the Board is subject to powers of renewal, suspension, revocation, denial, refusal to renew, ~~levying~~ criminal or civil penalties, vested in the Board by the Act and does not preclude the Board from using any other legal procedures necessary to carry out its powers and duties.

(8) A duplicate Certificate of Authority or Certificate of Title may be issued to an Entity provided:

(A) the current License or Registration renewal of the Architect(s) of Record or the Interior Designer(s) of Record is current and active and the Certificate of Authority or Certificate of Title is current and active;

(B) a written request for a replacement or duplicate Certificate of Authority or Certificate of Title is received; and

(C) the fee is paid as prescribed in 55:10-3-13.

55:10-13-6. Biennial Registration renewals required for Certificate of Authority or Certificate of Title

(a) ~~Biennial Registration renewal requirements. An Entity desiring to practice under the Certificate of Authority must submit the proper fees and applicable penalties in 55:10-3-13 and forms for application and renewal biennially. No Certificate of Authority shall be issued for longer than a two (2) year period. The renewal forms and fees shall be due with the Registrant's individual license renewal which is due by 4:30 p.m. on or before June 30 of the renewal year to avoid penalties. Postmarks will not be accepted. An Entity desiring to practice Architecture, Landscape Architecture or use the title Architect or Landscape Architect through a Certificate of Authority or an Entity desiring to represent themselves as an Interior Designer or offer services as interior design through a Certificate of Title, must submit the proper fees and applicable penalties in 55:10-3-13 and forms for application and renewal biennially. No Certificate of Authority or Certificate of Title shall be issued for longer than a two (2) year period. The renewal forms, required information and fees shall be due with the Licensee's~~

~~or Registrant's individual renewal which are due by 4:30 p.m. on or before June 30 of the renewal year to avoid penalties. Postmarks will not be accepted.~~

(b) ~~Late payment and penalty. reinstatement penalties. Failure to biennially register renew and remit payment of the renewal fee for the Certificate of Authority or Certificate of Title on June 30 of the renewal year will result in a late payment and penalty reinstatement penalties in 55:10-3-13 and cancellation of the certificate.~~

(c) **Renewal exemption based on temporary military deployment.** The exemption from fees and penalties shall apply to the Certificate of Authority or the Certificate of Title if a Licensee is the only Architect of Record or a Registrant is the only Interior Designer of Record associated with the Entity. Licensees or Registrants who are called to active military duty in the armed forces of the United States and deployed to a temporary military assignment are exempt from paying all renewal fees and penalties in OAC 55:10-3-13.

55:10-13-7. Failure to register biennially renew a for Certificate of Authority or Certificate of Title

(a) ~~Failure to biennially register the Entity and remit payment of the renewal fee, and penalties prescribed in the rules of this Chapter by July 1 of the renewal year will result in automatic suspension and revocation of the Certificate of Authority.~~

(a) Failure to biennially renew the Entity and remit payment of the renewal fee and applicable penalties, submit an acceptable and complete application and other required documents or information for the Certificate of Authority or Certificate of Title on June 30 of the renewal year will result in automatic cancellation and revocation of the certificate.

(b) ~~Notices of suspension or revocation will be sent to the last known address of the Entity failing to biennially register and remit renewal fees and penalties. Automatic cancellation and revocation of the Certificate of Authority or Certificate of Title will result in the Entity paying late payment and reinstatement penalties in addition to all other fee requirements in OAC 55:10-3-13.~~

(c) Notices of suspension or revocation will be sent to the last known address of the Entity failing to biennially License or Register and remit renewal fees and penalties.

55:10-13-8. Reinstatement of canceled Certificate of Authority or Certificate of Title

(a) **Reinstatement for nonpayment of fees.** A Certificate of Authority or Certificate of Title canceled for nonpayment of fees may be renewed upon ~~completion~~ submission of an updated acceptable and complete application form, provided the Entity currently meets all statutory requirements, the Rules of this Chapter and payment to the Board of the fees and penalties in OAC 55:10-3-13 have been paid, which have been accrued by the Entity at the time of reinstatement.

(b) **Reinstatement of Certificate of Authority or Certificate of Title for cause.** Certificates a Certificate of Authority or Certificate of Title suspended, denied, refused to renew be renewed, penalties levied, orders issued or revoked for

cause may be reinstated only by Board action and only then in the manner determined by such Board action.—~~Requests for reinstatement of the Certificate of Authority revoked for cause should be addressed to the Secretary Treasurer at the board office and shall show cause why such Board action is justified. Request for reinstatement may be filed by re-applying after all appeals have been exhausted and the further passage of six (6) months of suspension, refusal to renew, penalties levied, orders issued or revoked for cause. The request shall show the Board that the public interest will not suffer by reason of the reinstatement and should be addressed to the Secretary-Treasurer at the Board office. The Board has the sole discretion as to whether to reinstate the Certificate of Authority or Certificate of Title, deny the reinstatement and require the payment of all back fees and penalties.~~

(c) Reinstatement based on temporary military deployment. Entities given an exemption from paying fees and penalties because the only Architect of Record or Interior Designer of Record was deployed on a temporary military deployment in the armed forces of the United States, shall notify the Board office consistent with OAC 55:10-3-13.

55:10-13-9. Compliance with laws, Rules, regulations and orders

All entities shall comply with all laws, Rules, regulations and orders issued, which apply to an individual Architect, ~~or~~ Landscape Architect or Interior Designer.

55:10-13-10. Investigations, hearings and penalties

The Board shall investigate complaints, hold hearings, issue orders and determine penalties against entities in the same manner, procedure and with the same rights and offenses as an individual Architect, ~~or~~ Landscape Architect or Interior Designer as designated in the Rules of this Chapter.

55:10-13-11. Surrender of Certificate of Authority or Certificate of Title

Upon notice of the Board, Certificates of Authority or Certificates of Title suspended, refused to renew or revoked for cause by Board action shall be surrendered immediately in the manner prescribed by that notice.

55:10-13-12. Notification of changes in firm practice required

Entities shall notify the Board office within thirty (30) days of any or all changes that affect the Certificate of Authority or Certificate of Title. Notification shall be on the Board's form, signed by an Architect or Landscape Architect of Record, Interior Designer of Record, or another partner, director, officer, shareholder, principal or for a limited liability company, a manager or member of the Entity, notarized and accompanied by the fees in 55:10-3-13. Failure to properly and promptly notify the Board of these changes shall be cause for penalties, orders issued, revocation, refuse to renew or

suspend of the Certificate of Authority or Certificate of Title, as designated in the Rules of this Chapter.

55:10-13-13. Authority to use professional titles

(a) Only ~~persons~~ individuals holding current Licenses or Certificates of Registrations in Oklahoma and entities holding a current Certificate of Authority or Certificate of Title issued by the Board are authorized to employ the titles Architect, or Landscape Architect or Interior Designer or use any various construction of these words ~~thereof~~, in describing or identifying services, contracting or executing work.

(b) ~~No other person or Entity may employ the title Architect or Landscape Architect to describe persons, entities or services, nor do such unregistered~~ No unlicensed individuals or entities have authority to contract or execute architectural or landscape architectural services or offer services as interior design in this state unless they comply with OAC 55:10-9-1 and the Act and these Rules.

55:10-13-14. Certificate of Authority or Certificate of Title index maintained; restriction on similar names

(a) The Board office shall maintain a suitable index of each current Certificate of Authority or Certificate of Title issued, setting forth the pertinent facts.

(b) The name of the Entity shall not be the same or deceptively similar to the name of any other Entity then existing or which has existed within the preceding three (3) years, without the written consent of the previously existing Entity.

55:10-13-15. Limited partnerships and corporations required to file with Secretary of State

(a) ~~In order to practice in Oklahoma, limited~~ Limited partnerships, limited liability companies, limited liability partnerships, foreign and domestic corporations are required by law to file for a certificate of incorporation or domestication and maintain same with the Secretary of State.

(b) Failure of an Entity to properly file or register with the Oklahoma Secretary of State and maintain said Entity in good standing with the Oklahoma Secretary of State may result in revocation of the Certificate of Authority or Certificate of Title and disciplinary action pursuant to the Act and Rules in this Chapter.

55:10-13-16. Use of deceased or retired names in titles of firm name

Use of the names of deceased or retired licensed or registered partners or directors in a firm name is permissible. Stationary, advertisements, business cards and similar items circulated to the public, shall indicate the status and year the ~~person~~ individual retired or died. Retired ~~persons~~ individuals may also be listed as consulting Architects, ~~or~~ Landscape Architects or Interior Designers. Example:

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Doe, Smith & Jones
Architects and Interior Designers

John Doe Fred Jones
Deceased, Architect Interior Designer
~~1930-1988-2016~~ ~~1987~~2017

55:10-13-17. Use of multiple surnames in titles of firm name

Use of multiple surnames in titles of firms is permissible so long as one surname is a licensed Architect, ~~or Landscape Architect or registered Interior Designer~~. Other surnames shall be names of related licensed or registered professions (e.g., engineer - structural, mechanical, electrical, civil, or land surveyor). Example (where Doe is a licensed Architect, and Smith and Jones are licensed structural engineers):

Doe, Smith & Jones
Architects & Engineers

55:10-13-18. Use of full name in title of firm name

Use of a full name in the title of a firm is permissible so long as the full name is the name of a licensed Architect, ~~or Landscape Architect or a registered Interior Designer~~ or a deceased licensed Architect or Landscape Architect or registered Interior Designer. Example (where John C. Doe was a licensed Architect):

John C. Doe Company
Architects
John C. Doe (~~1930-1988-2040~~)

55:10-13-19. Use of departed person's surname in title of firm name

Use of a surname of an individual who has left a firm is permissible by written agreement for a period of two (2) years so long as all stationary, advertising, business cards and similar items note that individual's person's inactive status with the firm, the year and a current practicing licensed Architects or Landscape Architect's Architect, Landscape Architect or registered Interior Designer name, who is a general partner or director appears on all stationary, advertising, business cards and similar items. Example:

Doe & Smith
Architects & Engineers
John Doe, Architect David Williams
Inactive ~~1988~~2020 Architect Engineer

55:10-13-20. Use of fictitious name in title of firm name

Fictitious names of firms are permissible so long as at least one Architect of Record or Interior Designer of Record as defined in 55:10-1-3, ~~being has Direct Supervision and is in Responsible Control a licensed Architect or Landscape Architect responsible for the activities of the firm practice and the person's individual's name appears on all stationary, business cards and similar items.~~ Example:

The Gold Star Group
Architects & Engineers
John Brown, Architect
~~Licensed Architect~~

55:10-13-21. Use of single surname in title of firm name

Use of a single surname is permissible so long as that surname is a licensed Architect, Landscape Architect, registered Interior Designer, or related professional (e.g., engineer, structural, mechanical, electrical, or civil, or land surveyor). The entity shall also list the name of the licensed Architect, ~~or Landscape Architect, or registered Interior Designer~~ responsible for the activities of the firm practice and the individual's name appears on all stationary, business cards and similar items. Example (where Jones is a licensed related professional):

The Jones Group
Architects & Engineers & Land Surveyors
John Doe, Architect

SUBCHAPTER 15. VIOLATIONS

55:10-15-1. Prima facie evidence

~~An individual or Entity shall be construed to practice or offer to practice architecture or landscape architecture, within the meaning and intent of the State Architectural Act, who practices architecture or landscape architecture any branch of the professions the Board regulates, or who, by display or verbal claim, sign, advertisement, contract, card or other printed, engraved, or written instrument or device, or by electronic means, internet or e-mail bearing an individual's or Entity's name or in any other way represents to be a professional Architect, or Landscape Architect or through the use of some other title implies that the individual or Entity is a professional Architect or Landscape Architect, or that the individual or Entity is registered under this Act; or who holds himself/herself or itself out as able to contract for, offer or perform, or who does contract, offer or perform any architectural or landscape architectural service or work or any other service designated by the Act as the practice of architecture or landscape architecture. Any such action noted by this Section shall be sufficient to justify an injunction or any other order or a conviction without evidence of a general course of conduct. The Board shall determine if other~~

legal procedures and penalties are necessary and shall have the power to proceed with any and all legal procedures in addition to the injunction or other such orders issued.

Prima facie evidence shall be construed or attempting to construe to practice, perform or offer architecture, landscape architecture or services as interior design within the meaning and intent of the Act by display or verbal claim, sign, advertisement, contract, card or other printed, engraved, or written instrument or device, or by electronic means bearing an individual's or entities name or in any other way represent to be licensed or registered under the Act. Prima facie evidence is also defined as an individual or Entity representing as able to contract, offer, perform services or use the restricted titles defined under the Act as requiring a License, Registration, Certificate of Authority or a Certificate of Title. Any such action noted by this Section shall be sufficient to justify an injunction or any other order or a conviction without evidence of a general course of conduct. The Board shall determine if other legal procedures and penalties are necessary and shall have the power to proceed with any and all legal procedures in addition to the injunction or other such orders issued.

55:10-15-2. Grounds for violations and penalties

Grounds for probation, denial, revocation, suspension, refusal to renew, orders, injunctions, civil and/or criminal penalties are as follows:

- (1) Fraud, deception or misrepresentation in applying for a License, Certificate of Registration, Certificate of Authority, Certificate of Title or in taking the examinations (see 55:10-15-4);
- (2) Noncompliance with statutory requirements or Rules in this Chapter for qualifying for licensure a License or Registration;
- (3) Violating the State Architectural Act or any Rule in this Chapter, regulation or order issued by the Board;
- (4) Conviction of a felony;
- (5) Violating any other jurisdiction's registration or licensing laws, requirements or rules and regulations;
- (6) Mental impairment;
- (7) Gross incompetence (see 55:10-15-5);
- (8) Recklessness on the part of the Registrant-Licensee in designing, planning or observing the construction or alteration of a project or building (see 55:10-15-6);
- (9) Dishonest practice (see 55:10-15-7);
- (10) Failure to maintain a License or Registration in good standing in one additional jurisdiction for reciprocal Licenses or Registrants;
- (11) Loss of NCARB, or CLARB or NCIDQ certification for reciprocal license-Licenses or Registrants based on cause with Oklahoma;
- (12) Nonpayment of fees, ~~or~~ penalties, ~~or~~ failure to complete continuing education requirements, when applicable, or failure to file acceptable and properly completed required documents with the Board will result in automatic revocation;

(13) Unauthorized or misuse of seal which shall include sealing, dating and signing any or all documents not prepared under the Registrant's-Licensee's Direct Supervision and Responsible Control.

(14) Aiding and/or abetting unlicensed practice of architecture or landscape architecture.

(15) Sealing, signing and/or dating plans and/or specifications not prepared in accordance with the Act and/or these Rules.

(16) ~~Falsifying any~~ Giving false or forged evidence or documents submitted to the Board or generated in the practice of architecture or landscape architecture.

(17) Presenting the License or Registration of another as the individual's or Entity's own.

(18) Concealing information relative to any violation of the Act or the Board's Rules.

55:10-15-3. Additional penalties for violations

Civil penalties and legal costs incurred by the Board including reasonable attorney fees to prosecute the case may be levied by the Board separately or in addition to any other penalties determined by the Board. The Board may seek criminal and injunctive relief through the courts for any violation of the Act, Rules in this Chapter, regulation, or to enforce any order issued by the Board.

55:10-15-4. Fraud or misrepresentation

~~Any Registrant or Entity or person associated with any Registrant or Entity, holding a Certificate of Registration and/or a Certificate of Authority under this Act who shall make oral or written fraudulent, false or misleading statements concerning any Registrant or Entity or on any document, report, statement, examination, investigation, plans or specifications made by the Registrant or Entity or under his, her or its direct supervision or responsible control shall, upon conviction, be deemed guilty of fraud or misrepresentation. Fraud shall include copying any documents from an employer without specific written authorization. Any Architect, Landscape Architect, Interior Designer, Entity or any other party who shall make oral or written fraudulent, false or misleading statements on any document, report, statement, examination, investigation, plans or specifications shall, upon conviction, be deemed guilty of fraud or misrepresentation. Fraud shall include copying any documents from an employer without specific written authorization.~~

55:10-15-5. Gross incompetence

~~Registrants-Architects and Landscape Architects~~ have been licensed under the authority of the State Architectural Act that establishes minimum competence. ~~Registrants-Licenses~~ are expected to continue their professional development after licensing, improving and increasing their proficiency and skills as required through fulfillment of continuing education requirements. The Board expects each Registrant-Licensee or Entity to undertake only those professional assignments he/she or it is qualified to perform and lawfully authorized

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to undertake. The following practices, among others may be deemed gross incompetence:

- (1) Failure to use due diligence and proper restraint in planning and observation procedures, thus endangering the safety and welfare of the public.
- (2) Failure to engage other licensed design professionals, competent and authorized through this or other Oklahoma statutes to practice in related planning disciplines, when the ~~Registrant~~ Architect or Landscape Architect is otherwise responsible for obvious technical or tactical error jeopardizing the success or safety of the project, the public, the client and/or contractor.
- (3) Failure to clearly, accurately and completely develop plans, drawings, specifications and other instruments of service in practice that properly qualify the requirements intended and insure against misunderstandings jeopardizing the client and/or contractor.
- (4) Failure to use diligence and available counsel in preparing documents for the protection of a client in construction agreements involving the ~~Registrant's~~ Licensee's responsibility.
- (5) Practicing architecture or landscape architecture while mentally impaired.

55:10-15-6. Recklessness

- (a) The Architect or Landscape Architect is responsible for many technical and tactical judgments relating to construction materials, techniques and systems processes. His/her education, training and experience should enable him/her to make such determinations with confidence in a successful result.
- (b) The Board expects of its ~~Registrants, Licensees, Entities or persons~~ individuals representing same, prudent and deliberate consideration in such decisions, made only after responsible and thorough investigation, research and when necessary, expert advice and assistance.
- (c) When the result anticipated in such decisions is not reasonably predictable, each ~~Registrant, Licensee, Entity or person~~ individual representing same, is expected to so advise the client, fully disclosing the implications involved.
- (d) When such decisions promote procedures, techniques, materials, systems, etc., unfamiliar to the planning and/or building team involved, the ~~Registrant, Licensee, Entity or person~~ individual representing same, is expected to exercise extraordinary care and attention to the process, insuring as best he/she can the result sought.
- (e) If, in the judgment of the Board, a ~~Registrant, Licensee, Entity or person~~ individual representing same, does not demonstrate concern, attention and involvement stated in this Section, and failure to do so brings jeopardy to the project, public or client, the Board may deem such neglect to be recklessness.
- (f) A ~~Registrant Licensee~~ or Entity shall not aid or abet any unlicensed ~~person or Entity~~ party in practicing architecture or landscape architecture. Aiding and abetting shall include a ~~Registrant or Entity~~ party furnishing limited services in such a manner as to enable owners or unlicensed ~~persons~~ parties to evade the requirements of the ~~State Architectural Act~~ or Rules in this Chapter. Incomplete plans shall be clearly marked as

incomplete and not for construction if services are terminated during the contract.

55:10-15-7. Dishonest practice

Dishonest practice means the following practices, among others, may be deemed dishonest practice:

- (1) Acts which evidence violation, or attempts to violate, any laws or Rules of this or any other state relating to ~~licensing registration~~ or the practice architecture or landscape architecture.
- (2) Acts which evidence disregard or neglect in complying with regulations, codes, ordinances and recognized standards regulating construction at the place of building.
- (3) Acts which evidence attempts through commission or omission, to mislead or defraud any ~~party, person or Entity~~.
- (4) Acts which evidence attempts or success in efforts violating Rules in this Chapter regarding the use of an Architect's or Landscape Architect's seal, signature and date.
- (5) Acts which evidence attempts or success in efforts to bribe any ~~person or Entity~~ party, who may influence the selection of any ~~Registrant~~ Architect, Landscape Architect or Entity. Kickbacks, donations, or forgiveness offered or paid to gain improper advantage in selection will be considered bribes.
- (6) Acts which evidence attempts or success to conceal a ~~person's Licensee's or Entity's~~ interests in conflict with responsibilities of service to a client.
- (7) Acts which evidence improper partiality as arbiter or interpreter in matters relating to client/contractor agreements resulting in or from unauthorized waivers, deviations, or disregard of provisions in such agreements.
- (8) Acts evidenced by exaggerated, misleading, deceptive or false statements or claims about professional qualifications.
- (9) Falsifying any documents submitted to the Board or required to be kept by the ~~Registrant Licensee, Registrant, Entity~~ or generated in the practice of architecture or landscape architecture.
- (10) It shall be illegal to copy any documents or programs from the employer's files without expressed written consent by the employer.
- (11) Submitting forged documents or evidence to the Board.

55:10-15-8. Duty to refer alleged violations to Secretary-Treasurer

When information comes to the Board or its employees concerning alleged ~~violations of the Act or these Rules, misconduct by Registrant, entities or 's representing same, holding certificates of registration and/or Certificates of Authority or unlicensed practice of the professions regulated by the Board by unlicensed s or entities,~~ whether through formal or informal channels or by reason of other information, it shall be the duty of such body or ~~person~~ individual to refer such information to the Secretary-Treasurer.

55:10-15-9. Filing a complaint; forms and evidence

(a) When filing a formal complaint, the ~~person, Registrant or Entity party~~ shall contact the Board office for the forms required to be completed. The complainant shall document the allegations with evidence available and shall submit one original and two certified original copies to the Board office. The Secretary-Treasurer of the Board shall make appropriate inquiry to verify such information and shall, base upon such information and inquiry, proceed to one of the following courses:

- (1) Terminate the investigation when it appears no violation has occurred or there is insufficient evidence to support any violation; or
- (2) Refer the matter to the investigative committee; or
- (3) Appoint an individual investigator; or
- (4) Attempt informal resolution of the matter; or
- (5) Refer directly to Board.

(b) A Board member shall not discuss with any ~~person, individual,~~ any facts or circumstances concerning any investigation or formal complaint prior to holding a formal hearing, except in a Board meeting or with the Board's attorney.

55:10-15-11. Investigation committee

(a) **Appointment; officers.** The investigation committee, appointed by the ~~Chairman-Chair,~~ shall investigate such cases referred to it. The committee shall be appointed for terms as designated by the ~~Board Chair.~~ At least a majority of the members of the committee shall be licensed or registered and in good standing with the Board. The Board shall designate one member ~~Chairman-Chair~~ whose duty it shall be to conduct meetings of the committee, administer its activities and perform such other duties as are assigned by the Board.

(b) **Duties.**

(1) It shall be the duty of the investigation committee, upon request from the Secretary-Treasurer of the Board, to investigate to determine whether there exists probable cause to believe a that such misconduct or violation has occurred as to justify the institution of formal or civil proceedings. The investigation shall be conducted with reasonable dispatch. The investigative committee shall report to the Executive Director of the Board the result of any investigation promptly upon its conclusion. Such report shall include a summary of evidence considered by the committee including any materials provided by ~~the person or Entity to the committee, the committee's~~ their conclusions of fact and law, and ~~the committee's~~ recommendation with respect to institution of civil or formal proceedings. The committee may or may not, in its sole discretion, afford the ~~person or Entity accused party~~ involved an opportunity to be heard in the course of preliminary investigation.

(2) Before a report adverse to the ~~Registrant, Entity or person accused party~~ is made, the investigative committee shall may or may not, in its sole discretion, notify him/her or it in writing of the complaint and allow not less than ten (10) days to reply in writing. At this level of the proceedings the ~~Registrant, Entity or person accused party~~ shall not be entitled to a hearing before the investigative committee as a matter of right, but may submit, in writing, one

original and two certified original copies for consideration by the investigative committee which shall be included in the final report to the Executive Director.

55:10-15-12. Investigation report and recommendations

The Executive Director shall forward the investigative committee's report to legal counsel for the Board who shall proceed with the recommendations contained therein, provided such recommended action conforms to law or established policy of the Board and is supportable based upon evidence considered by the investigative committee and its conclusions. Civil or formal proceedings will not be instituted unless the investigation committee and counsel to the Board are agreed upon such action or unless ordered by the Board based upon review of the recommendations of the investigative committee and counsel of the Board. ~~The Registrant or person shall be promptly notified of pending action.~~ If formal charges are proposed without using the investigation committee, those charges shall be approved by the Secretary-Treasurer and the Executive Director before sent out by Counsel.

55:10-15-13. Investigator

Investigations may, at the discretion of the Secretary-Treasurer, be assigned to individual investigators who are employed or retained on a full or part-time basis by the Board for such purpose. Such investigators may make use of the investigative committee but shall be in full charge of any investigation so assigned subject only to direction by the Secretary-Treasurer or the Board and/or counsel to the Board.

55:10-15-14. Civil and formal proceedings

Civil or formal proceedings in matters involving ~~misconduct or violations by Registrants, entities or persons~~ shall be brought by Counsel or the Secretary-Treasurer of the Board based upon recommendation of the investigative committee, investigator, or when ordered by the Board. The formal complaint shall be signed by Counsel to the Board and/or Executive Director and shall include a concise statement of the allegations and particular sections of statutes and Rules in this Chapter involved.

55:10-15-15. Hearings

(a) **General provisions.**

(1) The Board shall set a time and place for the hearing of charge, provided that such hearing shall not be set less than twenty (20) days from mailing of notice of the proceeding to the ~~Registrant, or at the last known address of~~ the accused party according to Board records or information.

(2) Such notice shall include a copy of the charge, a statement of the time, place and nature of the hearing, a statement of the legal authority and jurisdiction under which the hearing is held; of the matters asserted or issues

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involved. At any hearing interested parties shall be afforded the opportunity to respond, present evidence, and argue on all issues involved.

(3) Unless precluded by law, informal disposition may be made of any proceeding by stipulation, agreed settlement, consent order, or default.

(4) At any hearing the party Registrant or Entity charged with misconduct or violation of the Act or Rules shall enjoy the following rights:

(A) against self-incrimination in testimony before the Board. However, any previous testimony before a court or inquiry of public record, may be used in evidence; and

(B) of confidential communication with his spouse, attorney, clergyman, priest and/or physician; and

(C) of withholding such other records and files of any official or agency of any state or of the United States which, by any statute of such state or of the United States, are made confidential or privileged; and

(D) of cross examination; and

(E) of counsel.

(b) Hearing record.

(1) The hearing record shall include:

(A) All pleadings, motions and intermediate rulings;

(B) Evidence received or considered;

(C) Questions and offers of proof, objections, and rulings thereon;

(D) Proposed findings and exceptions;

(E) Any decision, opinion, or report by the officer presiding at the hearing;

(F) All staff memoranda or data submitted to the hearing officer or members of the agency in connection with their consideration of the case. This does not include staff memoranda or data submitted or communicated to Counsel for the Board, unless used in the hearing.

(2) Oral proceedings or any part of the oral proceedings shall be transcribed on request of any party.

(3) Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

(c) **Methods of hearings.** Hearings shall be conducted by one of the following methods, as determined by the Board:

(1) By the Board;

(2) By any member of the Board or its designee acting as hearing examiner;

(3) By any attorney licensed to practice before the Supreme Court of the State of Oklahoma acting as hearing examiner.

55:10-15-18. Findings of the Board and penalties

(a) The Board may find:

(1) The charges are dismissed for insufficient evidence;

(2) The charges are dismissed without prejudice;

(3) The charges are dismissed with prejudice;

(4) The defendant is found not guilty;

(5) The defendant is found guilty;

(b) If the finding is guilty, the Board shall then determine the penalty to be imposed. The penalty resulting from a finding of guilty shall be one or more of the following:

(1) Reprimand: The formal notice of the Board, not subject to public notice, that the accused ~~Registrant or Entity~~ party has been found guilty of violations which can and must be corrected as instructed; failure for which may result in suspension, revocation, probation or a civil penalty.

(2) Censure: The formal notice of the Board, subject to public notice, that the accused ~~Registrant or Entity~~ party has been found guilty of violations which cannot be corrected, and which if repeated may result in suspension, revocation, probation, denial, refusal to renew, or civil penalty.

(3) Suspension: The formal notice of the Board, subject to public notice, that the finding of guilty had resulted in suspension, denial, probation or refusal to renew the accused individual's License, Registration, and/or Certificate of Authority or Certificate of Title for a stated period. In addition, a civil penalty may also be imposed.

(4) Revocation: The formal notice of the Board, subject to public notice, that the finding of guilty has resulted in revocation of the accused individual's License, Registration, and/or Certificate of Authority or Certificate of Title. In addition, a civil penalty may also be imposed.

(5) Civil Penalty: The formal notice, at the discretion of the Board, may be subject to public notice that the finding of guilty of the accused ~~Registrant or Entity~~ party has resulted in a civil penalty, as provided by the Act.

(6) Probation: The formal notice of the Board, subject to public notice, that the accused ~~Registrant or Entity~~ party has been found guilty of violations which cannot be corrected, and which if repeated may result in suspension, revocation, denial or refusal to renew and/or civil penalty.

(c) All disciplinary actions where the ~~Registrant or Entity~~ party has been convicted, pled guilty or nolo contendere to a violation of the Act or Rules, shall be publicized to the public and profession with their name, License or Registration number and/or the Certificate of Authority or Certificate of Title number and the city and state on the Board's records, if applicable.

55:10-15-19. Proposed hearing orders

At any hearing not heard by a majority of the members of the Board or when the case hearing record has not been read by a majority of the members of the Board, the decision, if adverse to a party to the proceeding, shall not be made until a proposed order is served upon the parties and an opportunity is afforded to each party adversely affected to file exceptions and present briefs and oral argument to the Board. The proposed order shall be accompanied by statements of the reasons therefore and of each issue of fact or law necessary to the proposed order, prepared by the ~~person-individual~~ who conducted the hearing or by one who has read the record. The parties may, by written stipulation waive compliance with this Section.

55:10-15-21. Final orders

A final order adverse to a party in a proceeding shall be in writing or stated in the record. A final order shall include findings of fact and conclusions of law, separately stated. Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. Parties shall be notified either personally individually or by mail of any order. Upon request, a copy of the order shall be delivered or mailed to each party and to the attorney of record.

55:10-15-22. Procedures to file exceptions to proposed orders

Exceptions shall be filed with the Executive Director within ten (10) days of mailing the proposed order to the ~~Registrant or Entity~~ party. If exceptions are filed, the Executive Director shall set the time and place for the Board to consider the proposed order and the exceptions to it and cause notice of such time and place to be mailed to the ~~Registrant or Entity~~ party. Such time shall not be less than twenty (20) days after such notice is mailed. Briefs in support of exceptions must be filed with the Board at least seven (7) days before such hearing. The ~~Registrant or Entity~~ party may individually or through counsel be present and present oral argument to the Board in support of the exceptions. If no exceptions are filed, the Board will consider the proposed order at its next regular or special meeting, or at such other time as is convenient to the Board.

55:10-15-23. Rehearing, reopening or reconsideration

(a) A decision by the Board shall be subject to rehearing, reopening, or reconsideration by the Board if requested within ten (10) days from the date of its entry. The grounds for requesting such action shall be either:

- (1) Newly discovered or newly available evidence relevant to the issues; or
- (2) Need for additional evidence adequately to develop the facts essential to proper decision; or
- (3) Probable error committed by the Board or hearing examiner in the proceeding or in its decision such as would be grounds for reversal on judicial review or the order; or
- (4) Need for further consideration of the issues and the evidence in the public interest; or
- (5) A showing that issues not previously considered should be examined in order to properly dispose of the matter; or
- (6) Fraud practiced by the prevailing party or of procurement of the order by perjured testimony or fictitious evidence.

(b) The order of the Board granting rehearing, reconsideration, or review, or the petition of a party, shall set forth the grounds that justify such action.

(c) The Board will consider past ~~disciplinary action~~ violations taken against any Registrant, or Entity party found guilty of misconduct in any present proceeding. Such past ~~conduct violation~~ shall not be evidence of guilt in the present proceeding but will be considered only in determining appropriate

sanctions or penalties to be imposed by the Board in the present proceeding.

(d) Unless precluded by law, any party may waive rights and proceed by stipulation, agreed settlement, consent order or default. No provision in the Rules of this Chapter shall be construed as prohibiting the Board from suspending or holding in abeyance any formal or civil proceeding pending the outcome of informal negotiation or informally agreed upon terms.

55:10-15-24. Other hearings

~~When it comes to the Board's attention that persons or entities residing in or out of the State of Oklahoma may be engaged the practice of architecture or landscape architecture in Oklahoma as defined by the State Architectural Act and the Board's current Rules in this Chapter, and further that such persons or Entity may be engaged in the unauthorized practice of these professions or may not meet the requirements thereof, the Board may institute proceedings or penalties as provided in the Rules of this Chapter against such Registrants, persons or entities for the purpose of determining if any violation of the law, Rules in this Chapter or orders has occurred and may take such action as is permitted pursuant to the provisions of 59 O.S., Sections 46.1 et seq. and may, in addition, bar said Registrant, person or Entity and their employers from obtaining Registration with the Board or the practice of Architecture, Landscape Architecture within the State of Oklahoma. When it comes to the Board's attention that a party residing in or out of the State of Oklahoma may be engaged in any illegal activity that might be determined as a violation of the Act, these Rules, penalties or orders issued by the Board, the Board may take any necessary legal action permitted pursuant to the provisions of 59 O.S., Sections 46.1 et seq. and may, in addition, bar the individual or Entity and/or their employers from obtaining a License, Registration, Certificate of Authority and/or Certificate of Title.~~

55:10-15-25. Emergency hearings and orders

(a) If the Board shall find an emergency to exist which, in the opinion of the Board, poses an immediate danger to the public health, welfare, or safety or which threatens irreparable harm to any ~~person or Entity party~~ the Board may order hearings as provided in this Section upon the giving of twenty-four (24) hour notice to the parties concerned, and may enter such temporary orders as will, in the judgment of the Board, maintain or restore the public health, welfare, and safety pending hearing by the Board or judicial review of the Board's actions.

(b) Whenever in the judgment of the Board any ~~Registrant or Entity party~~ has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of the Act or these Rules, the Board may make application to the appropriate court for an order enjoining such acts or practices, and upon a showing by the Board that such ~~Registrant or Entity party~~ has engaged, or is about to engage, in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court, without bond.

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(c) Nothing in the Rules of this Chapter dealing with violations, penalties or findings of facts shall preclude the Board from proceeding through any legal proceedings necessary to enforce its findings, orders or penalties.

SUBCHAPTER 17. CONTINUING EDUCATION REQUIREMENTS

55:10-17-1. Purpose

These Rules provide for a continuing education program to insure that all Architects and Landscape Architects licensed in the state remain informed of technical and professional subjects ~~that which~~ the Board deems appropriate to ~~the professional architectural practice of architecture and landscape architecture~~ and to safeguard life, health, and promote the public welfare.

55:10-17-2. Board responsibilities

(a) The Board shall:

- (1) Perform continuing education audits of ~~Registrants Architects and Landscape Architects.~~
- (2) Determine if courses address the health, safety and welfare of the public through an audit.
- (3) Discipline ~~Registrants Architects and Landscape Architects,~~ as may be appropriate.

(b) Members of the Board may attend courses for purposes of auditing the content and compliance with this rule.

55:10-17-3. Noncompliance and sanctions

The continuing education requirements contained in this Section will apply to every ~~Registrant Architect and Landscape Architect,~~ as a condition for ~~the renewal of said renewing of his/her and/or the Certificate of Authority.~~ Failure to fulfill the continuing education requirements, or file the required biennial report and affidavit, properly completed and signed, or to pay all required fees by June 30th of the renewal year, shall result in non-renewal of ~~a Registrant's registration-an Architect's or Landscape Architect's License and/or Certificate of Authority.~~ ~~If a license is not renewed for any reason, the Registrant must immediately cease the practice of architecture or landscape architecture. Persons who continue to practice architecture or landscape architecture during the time of License delinquency are subject to the fines, penalties and civil remedies contained in the Act and these Rules.~~

55:10-17-4. CEU-Continuing education requirements

(a) Beginning with applications for renewal of licenses which expire on June 30, 2001, each ~~Registrant Architect and Landscape Architect~~ shall have completed 24 CEU's of acceptable continuing education requirements during the two-year period immediately preceding the biennial renewal date as a condition for License renewal. One CEU shall represent one Contact Hour. No credit will be allowed for introductory remarks, meals, breaks, or business/administration matters related to courses of study.

(b) If the ~~Registrant Architect or Landscape Architect~~ exceeds the continuing education requirements in any renewal period, the ~~Registrant Licensee~~ may carry a maximum of 4 CEU's forward into the subsequent renewal period.

55:10-17-5. Exemptions

~~A Registrant~~ An Architect or Landscape Architect may be exempt from participating in the continuing education program required by these Rules for one of the following reasons:

- (1) A first-time ~~Registrant License~~ issued by examination or ~~first time reciprocal Registrant reciprocity~~ shall be exempt for his/her first renewal period if the first renewal period is less than two years from the original date of licensure. A ~~Reciprocal Registrant Licensee~~ will be exempt from ~~the these~~ requirements of ~~this Subchapter~~ if the Licensee is licensed in another jurisdiction and has met continuing education requirements ~~are~~ equal to or exceeding the requirements of this Subchapter. The ~~Registrant Licensee~~ shall certify to the Board that the requirements of this Subchapter have been met and ~~shall~~ substantiate same when audited.
- (2) ~~A Registrant~~ An Architect or Landscape Architect who has taken emeritus status must certify to the Board that ~~the Registrant they~~ are not currently practicing architecture or landscape architecture. In the event the emeritus ~~Registrant individual~~ elects to return to active practice, the ~~Registrant individual~~ shall earn CEU the continuing education required for the current licensing period, not to exceed two (2) years.
- (3) ~~A Registrant~~ An Architect or Landscape Architect called to active military duty in the armed forces of the United States ~~for a period of time exceeding one hundred and twenty (120) consecutive days during a fiscal year~~ shall be exempt from obtaining the ~~CEU's continuing education required for the duration of the temporary deployment and all penalties, if applicable and shall comply with OAC 55:10-3-13.~~
- (4) ~~A Registrant~~ An Architect or Landscape Architect experiencing physical disability, illness or other extenuating circumstances may request exemption from the continuing education requirements. The ~~Registrant individual~~ shall provide supporting documentation for the Board's review. Such hardship cases will be considered by the Board on an individual basis.

55:10-17-6. Computation of credits

Continuing education credits shall be measured in CEUs and shall be computed as follows:

- (1) successfully completing one Contact Hour in course work, seminars or making professional or technical presentations at meetings, conventions or conferences shall be the equivalent of one CEU;
- (2) teaching or instructing a qualified presentation, approved by the Board, shall constitute two CEUs for each hour spent in the classroom. Teaching credit shall be valid for teaching a course or seminar in its initial presentation only. Teaching credit may be claimed by full-time faculty

at a college, university or other educational institution for the initial presentation only and shall be related to health safety, welfare issues only;

(3) authoring a published paper, article, writing a CEU continuing education course or a book shall be the equivalent of 24 CEUs (No CEU's will be approved for newspaper or similar news articles);

(4) successfully completing one university semester hour of credit shall be the equivalent of 12 CEUs;

(5) mentoring other individuals in the Licensee's profession in extra curricular settings and activities. Credit shall be two (2) Contact Hours equals one CEU.

55:10-17-7. General course/program requirements

(a) All programs and courses are subject to auditing and the Board may disapprove any course not meeting the intended continuing education criteria set forth in this Subchapter.

(b) All courses sponsored by NCARB, CLARB, The American Institute of Architects and the American Society of Landscape Architects will count for the required continuing education requirements if they met the requirements of this Subchapter and the intent of the Board.

(c) Continuing education courses must be at least one Contact Hour in length and meet the topic area guidelines described in this Subchapter.

(d) Continuing education courses will be approved or disapproved by the Board based upon the information presented at the time of audit.

(e) To qualify for continuing education, the course must:

(1) include technical and practical applications which impact public health, safety and welfare and,

(A) maintain, improve, expand or enhance the quality of the existing technical knowledge;

(B) fill voids that may exist in the professional education and internship training; or

(C) develop new and relevant technical profession skills and knowledge.

(2) have clear purposes and objectives;

(3) be well organized, presented in a sequential manner, and provide evidence of pre-planning;

(4) be presented by ~~persons~~ individuals who are well-qualified by education or experience in the field being taught; and

(5) provide individual participant documentation for record keeping and reporting.

(f) ~~Registrants, Architects and Landscape Architects~~ may secure continuing education credit through the following types of programs and courses:

(1) attending professional or technical presentations at meetings, conventions or conferences;

(2) attending in-house programs sponsored by corporations or other organizations;

(3) successfully completing seminars, tutorials, short courses, correspondence courses, televised courses or video-taped courses;

(4) making professional or technical presentations at meetings, conventions or conferences;

(5) teaching or instructing, complying with OAC 55:10-17-6;

(6) authoring published papers, articles or books;

(7) successfully completing college or university sponsored courses; and

(8) mentoring other individuals in the Licensee's profession in extra curricular settings and activities. Credit shall be two (2) Contact Hours equals one CEU.

(g) Subject content acceptable for purposes of architecture continuing education shall be limited to:

(1) Study of Codes including safety codes, and laws and regulations governing the practice of architecture.

(2) Environmental Issues.

(3) Design proficiency.

(4) Study within planning, engineering, interior design, construction contracting and related disciplines.

(5) Legal aspects of contracts, documents, insurance, bonds, project administration, etc.

(6) Specialization, preservation, adaptive reuse, building types) etc.

(7) Construction Documents and Services.

(8) Materials and Methods.

(9) Mechanical, Plumbing, Electrical and Life Safety.

(10) Structural technology.

(11) Energy efficiency.

(12) Project administration.

(13) Professional ethics.

(14) Americans with Disabilities Act guidelines.

(h) Subject content acceptable for purposes of landscape architecture continuing education shall be limited to:

(1) Study of Codes including safety codes, and laws and regulations governing the practice of landscape architecture;

(2) Environmental issues;

(3) Design proficiency;

(4) Study within planning, engineering, horticulture, construction contracting and related disciplines;

(5) Legal aspects of contracts, documents, insurance, bonds, project administration, etc.

(6) Specialization in areas of concentration;

(7) Construction documents and sources;

(8) Project administration;

(9) Professional ethics;

(10) Safety guidelines (Playgrounds, trails, etc.);

(11) Herbicide and pesticide use;

(12) ~~ADA~~ American Disability Act Guidelines;

(13) Irrigation system design;

(14) Grading and drainage.

55:10-17-8. Instructional guidelines

Methods of instruction used for course delivery include personal presentation, correspondence and video courses or other learning techniques. ~~which may be pre-approved by the Board.~~ Instructional guidelines for the presentation of such course include the following:

(1) ~~In Person~~ Personal presentation courses must include:

(A) Course presentation and materials,

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- (B) Question and answer sessions (optional), and
- (C) Evaluation (optional)
- (2) Correspondence courses must include:
 - (A) Pre-course instruction book and course materials,
 - (B) Question and answer (optional),
 - (C) Evaluation (optional) and
 - (D) Testing (optional).
- (3) Video courses must include:
 - (A) Pre-course instruction book and course materials,
 - (B) Lecture,
 - (C) Question and answer (optional),
 - (D) Evaluation (optional) and
 - (E) Testing (optional).

55:10-17-9. Disallowance

- (a) The Board has final authority with respect to approval of courses, credits, and ~~CEUs~~ continuing education hours.
- (b) If the Board determines through an audit, that continuing education ~~credits—hours~~ are to be disallowed, ~~Registrants—an Architect or Landscape Architect~~ shall have 30 calendar days after notification to substantiate the original claim or earn other continuing education ~~credits—hours~~ to meet minimum requirements and submit documentation to the Board office.
- (c) Fraud or misrepresentation in certification of course attendance or any other aspect of fulfilling continuing education requirements will be disciplined in accordance with the Act, including revocation or denial of the renewal of a ~~Registrant License and/or Certificate of Authority, if applicable~~.

55:10-17-10. Registrant-Licensee responsibilities

- (a) The ~~Registrant—Architect or Landscape Architect~~ is responsible for retaining proof of participation in continuing education activities. Such verification includes, the following as applicable:
 - (1) A log showing activity claimed, sponsoring organization, location, duration, etc.; or
 - (2) Attendance certificates; or
 - (3) Signed attendance receipts; or
 - (4) Sponsor's list of attendees (signed by a ~~an~~ individual in responsible charge of the activity).
- (b) These records must be retained ~~for a period of four years—until January 1st~~ following the filing of an application for License renewal. Copies shall be furnished to the Board for audit purposes if requested.
- (c) The ~~Registrant—Architect or Landscape Architect~~ must be present for the entire duration of the course for all approved course Contact Hours.

55:10-17-11. Biennial report and affidavit

- (a) Each ~~Registrant—Architect or Landscape Architect~~, at License renewal, shall submit an affidavit attesting to the ~~Registrant's—individual's~~ fulfillment of continuing education requirements during the two years preceding the renewal. Affidavits, with an accompanying report concerning the courses

taken by the ~~Registrant—individual~~ to fulfill continuing education requirements, shall be submitted either on the back of the Licensee's renewal form on a form(s)—provided by the Board or attached separately to the renewal form.

- (b) Each affidavit shall be reviewed by the Board's staff for completeness, and may be subject to audit for verification of compliance with requirements. ~~Registrants—Architects and Landscape Architects~~ shall retain proof of fulfillment of requirements until January 1st for a period of four years after submission in the event that the affidavit and report is selected for audit.

- (c) ~~The Board may, upon audit for verification of compliance, disallow claimed credit for continuing education. The Registrant shall have 30 calendar days after notification of disallowance of credit to substantiate the original claim or earn other CEU credit which fulfills minimum requirements.~~

55:10-17-12. Requirements and responsibilities

- (a) The Board has set forth the following criteria that will be reviewed in approving ~~CEU credits—continuing education hours~~:

- (1) ~~Subject area expertise of Sponsor and/or instructor(s).~~ (1) Subject matter meeting the intent and purpose of requiring continuing education for Architects and Landscape Architects that complies with the requirements of the Act and these Rules.

- (2) ~~Experience or demonstrated ability in written instructional material and testing.~~

- (3) ~~Experience of Sponsor.~~

- (4) ~~Ability of Sponsor to provide course evaluation forms to participants, if applicable.~~

- (5) ~~Ability of Sponsor to provide reporting certificates or letters to participants.~~

- (b) ~~Courses shall be presented in the format established, including all handouts, scheduling and course content.~~

- (b) Courses shall be related to health, safety or welfare only as defined by NCARB and adopted by this Board. Welfare is also defined as the Licensee participating in an architecture or landscape architecture mentoring program for the benefit of students.

- (c) ~~The instruction level (either core, intermediate or advance) of courses being advertised, in information sent to Registrants, should be identified. Registrants are encouraged to take programs of intermediate and advanced levels.~~

- (c) Architects and Landscape Architects are encouraged to take programs of intermediate and advanced levels.

- (d) ~~Courses are required to issue issuing reporting certificates to Registrants, upon completion of a course. Completion of a course is considered the end of the course. There are no partial credits. Reporting Certificates should contain no less than the following information: participant's name, license number, sponsor name, course title, number of contact hours, date course given, sponsor or monitor signature.~~

- (d) Courses that are issuing reporting certificates should contain the following: participant's name, sponsor name, course title, number of contact hours, date course given, sponsor or monitor signature.

~~(e) Registrants shall maintain a record of all reporting certificates issued for a period of four years following the issuance of same. Sponsors shall maintain security regarding the release of reporting certificates. Duplication or falsification, as well as misuse, of reporting certificates may be grounds for disciplinary action against the Registrant.~~

~~(e) Licensees shall maintain a record of all reporting certificates or other documentation issued for verification of attendance until January 1st after submitting the License renewal. Duplication or falsification, as well as misuse, of reporting certificates or other documentation may be grounds for disciplinary action against the Licensee.~~

~~(f) Courses must should issue to attendees seeking continuing education credit, a "Course Evaluation Summary Form." Completed evaluations from each attendee must be retained for four years after the course/program.~~

~~(g) Courses shall verify identity of course participants. Sponsors should verify the identity of course participants.~~

~~(h) Sponsors shall contact Registrants regarding courses. Sponsors are encouraged to publicize their courses, ~~whenever and wherever offered.~~ In order to do so, lists A list of licensed Architects and/or Landscape Architects may be secured for a nominal fee from the Board. Applicable fees must be submitted with the request. The Board shall have thirty (30) days from receipt of the request to process and provide the requested listing.~~

~~(i) Registrants Architects and Landscape Architects cannot claim or obtain partial credit for portions of courses taken. If a Registrant cannot complete the entire course, no credit is to be claimed or approved by the Board.~~

~~(j) Sponsors shall monitor all attendees to ensure attendance for complete contact hour credit as follows:~~

- ~~(1) Identify all attendees seeking Board credit.~~
- ~~(2) Provide reasonable times for break and meal recesses.~~
- ~~(3) Review attendance.~~
- ~~(4) Other Brief absences or tardiness during a course offering are discouraged, however, if necessary the total of the absence of the attendee from the course contact shall not exceed 10% of the course Contact Hours.~~

~~(j) Brief absences or tardiness during a course offering are discouraged, however, if necessary the total of the absence of the attendee from the course should not exceed 10% of the course Contact Hours.~~

~~(k) Administrative procedures and introductions shall should be limited to no more than 10% of the course's approved Contact Hour credits. Specific course content shall ~~—should~~ utilize no less than ~~90%~~ 80% of the course Contact Hours.~~

~~(l) It is the responsibility of the Sponsor to offer a course in an environment and atmosphere appropriate to teaching and the course being presented.~~

[OAR Docket #07-716; filed 4-6-07]

**TITLE 85. STATE BANKING DEPARTMENT
CHAPTER 15. MONEY ORDERS/SALE OF
CHECKS/MONEY SERVICE BUSINESSES**

[OAR Docket #07-714]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 1. General Provisions and Definitions [NEW]
 - 85:15-1-1. Scope and purpose [NEW]
 - 85:15-1-2. Definitions [NEW]
 - 85:15-1-3. Exclusions [NEW]
- Subchapter 3. Money Transmission Licenses [NEW]
 - 85:15-3-1. License required [NEW]
 - 85:15-3-2. Application for license [NEW]
 - 85:15-3-3. Security [NEW]
 - 85:15-3-4. Issuance of license [NEW]
 - 85:15-3-5. Renewal of license [NEW]
 - 85:15-3-6. Net worth [NEW]
- Subchapter 5. Authorized Delegates [NEW]
 - 85:15-5-1. Relationship between licensee and authorized delegate [NEW]
 - 85:15-5-2. Unauthorized activities [NEW]
- Subchapter 7. Examinations; Reports; Records [NEW]
 - 85:15-7-1. Authority to conduct examinations [NEW]
 - 85:15-7-2. Cooperation [NEW]
 - 85:15-7-3. Reports [NEW]
 - 85:15-7-4. Change of control [NEW]
 - 85:15-7-5. Records [NEW]
 - 85:15-7-6. Money laundering reports [NEW]
- Subchapter 9. Permissible Investments [NEW]
 - 85:15-9-1. Maintenance of permissible investments [NEW]
 - 85:15-9-2. Types of permissible investments [NEW]
- Subchapter 11. Enforcement [NEW]
 - 85:15-11-1. Suspension and revocation [NEW]
 - 85:15-11-2. Suspension and revocation of authorized delegates [NEW]
 - 85:15-11-3. Orders to cease and desist [NEW]
 - 85:15-11-4. Consent orders [NEW]
 - 85:15-11-5. Civil penalties [NEW]
 - 85:15-11-6. Hearings [NEW]

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ANALYSIS:

The rules will be new to Chapter 15 of Title 85 of the Oklahoma Administrative Code. Chapter 15 had heretofore been "reserved" for rules under the Oklahoma Sale of Checks Act (Title 6 O.S. § 2101 *et seq.*). The heading of Chapter 15 is being amended to reflect its general application to

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all types of "money service businesses" ("MSBs") which may include sellers of checks, money transmitters, check cashers, *etc.* However, the only entities covered by the new rules are money transmitters.

The rules are a result of the enactment of the Oklahoma Financial Transaction Reporting Act (Title 6 O.S. § 1511 *et seq.*), effective April 17, 2006 (the "OFTRA"). The OFTRA requires the registration and licensing of money transmitters and allows for the promulgation of rules by the Oklahoma State Banking Board. The intended effect of the rules is to further clarify the registration and licensing requirements to be imposed on money transmitters, implement safety and soundness and consumer protection requirements on money transmitters, and define the role of the Banking Department as the licensing agency.

Subchapter 1 of the rules (General Provisions and Definitions) indicates that the scope of the registration and licensing requirements will be more narrow than called for by the OFTRA. The Legislature gave the Banking Board authority to narrow or broaden the scope of the licensing requirement. While the OFTRA imposed licensing requirements on all MSBs (defined in the OFTRA to include money transmission companies and their agents), Subchapter 1 provides that the licensing requirement will apply to money transmitter companies but not their "authorized delegates." The definitions provided in Subchapter 1 define important terms such as "authorized delegate," "licensee," "money transmission," and "unsafe and unsound practice." Additionally, Subchapter 1 identifies ten types of entities to which the OFTRA will not apply, such as government agencies, banks (defined to include banks, trust companies, credit unions, and savings associations), and certain commodities merchants and securities broker-dealers.

Subchapter 3 (Money Transmission Licenses) includes the requirement and procedures relating to applying for, renewing, and maintaining a license to engage in money transmission. The contents of a license application are set forth in rule 85:15-3-2 and an application form will be made available pursuant to that rule. Additionally, consumer protection requirements to maintain security (such as a surety bond) and minimum net worth (depending on the number of "authorized delegates") are set out in rules 85:15-3-3 and 85:15-3-6, respectively. In order to renew a license, a licensee must submit a renewal report, utilizing a form that will be prescribed pursuant to Rule 85:15-3-5. With regard to licensing and renewal fees set by Subchapter 3, the rules will significantly lower the fees otherwise called for by the OFTRA. The OFTRA required a separate license for all MSBs (which included money transmission companies and their authorized delegates). The fee set by the OFTRA is \$500 per licensee (*i.e.*, the fee was set at the same amount called for by Title 6 O.S. § 104(B), which is implemented by Banking Board Rule 85:10-3-21(j)). Therefore, under the fee set by the OFTRA, if a company utilized 100 authorized delegates in Oklahoma, its annual licensing fee would be at least \$50,000 (100 x \$500). Under the adopted fee schedule, that same company with 100 authorized delegates would incur a one-time application fee of \$3,000, an annual licensing fee of \$2,000, and \$50 (annually) per authorized delegate, for a total initial fee of \$10,000. Annual renewal fees for that same company would be \$7,000 (because the initial application fee would not be charged in subsequent years), for a total annual fee reduction of \$43,000 from that called for by the OFTRA. Subchapter 5 (Authorized Delegates) contains provisions that prohibit an authorized delegate (or any other person) from providing money transmission services for a person that does not have a license under the OFTRA or on behalf of a licensee whose license has been suspended or revoked. The use of subdelegates is also prohibited.

Subchapter 7 (Examinations; Reports; Records) authorizes the Banking Commissioner or another agency authorized by the Commissioner to conduct an on-site examination of a licensee or its authorized delegates. However, while examinations are authorized, the more common form of supervision will be through annual reports, called for by rule 85:15-7-3.

If a licensee undergoes a change of control, rule 85:15-7-4 requires notice to, and approval by, the Banking Commissioner. A fee equal to that required for a new license application must accompany the notice. This is because the rule requires the Commissioner to investigate the new controlling party to assure the competence, experience, character, and general fitness of such party to operate the licensee and that the public interest will not be jeopardized by the change of control.

With respect to record keeping, rule 85:15-7-5 requires both licensees and authorized delegates to maintain certain records for 3 years. Authorized delegates must comply with customer identification laws promulgated by the United States Department of the Treasury with respect to wire transfers of \$1,000 or more. Federal law currently requires compliance with customer identification requirements with respect to wire transfers of \$3,000 or more.

Subchapter 9 (Permissible Investments) requires money transmitters to maintain a certain level of investments that are equal to the value of their

outstanding obligations as a means of protecting individual consumers. This is another safety and soundness requirement designed to safeguard funds received from consumers. The list of permissible investments reflects existing industry practice. However, limitations are placed on the percentages of holdings in many of the investment categories because some permissible investments are riskier than others. The current list of permissible investments is an attempt to balance the concerns of regulators for safety and soundness and of industry participants who have concerns about their ability to properly conduct business. Receivables from authorized delegates are included as a category of permissible investments.

Subchapter 11 (Enforcement) describes the circumstances under which the Commissioner may suspend or revoke a license or order a licensee to revoke the designation of an authorized delegate. The Commissioner may also take action directly against an authorized delegate. This is an important mechanism for the prevention of money laundering and drug trafficking. If the Commissioner determines that a violation of the OFTRA is likely to cause immediate and irreparable harm to the licensee, its customers, or the public as a result of the violation, or cause insolvency or significant dissipation of assets of the licensee, the Commissioner may issue an order requiring the licensee or authorized delegate to cease and desist from the violation. The Commissioner may also assess a civil penalty against a person that violates the OFTRA. The issuance of a cease and desist order, suspension and revocation of a license, or assessment of civil money penalties may only occur after a hearing in accordance with Oklahoma's administrative procedure act.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS AND DEFINITIONS

85:15-1-1. Scope and purpose

This Chapter sets forth the supervisory and regulatory requirements, procedures, and standards for licensing of money transmitters under the Oklahoma Financial Transaction Reporting Act (Title 6 O.S. §§ 1511 - 1515). That Act generally requires the registration and licensing of money service businesses and gives the State Banking Board authority to clarify and define by rule the application of the Act. These rules are intended to apply the licensing requirements to money transmitter companies but not their authorized delegates, except as otherwise provided. Furthermore, these rules create standards for approval of such licenses, such as requiring a security bond for the protection of the public. Applicants for a license that have filed an application within 90 days of the effective date of the rules under this Chapter will be deemed to be in compliance with this Chapter until such time as the Commissioner grants or denies the license application.

85:15-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise.

- (1) "Act" means the Oklahoma Financial Transaction Reporting Act, Title 6 O.S. § 1511 et seq., and all rules promulgated under that Act.
- (2) "Applicant" means a person that files an application for a license under the Act.
- (3) "Authorized delegate" means a person a licensee designates to provide money services on behalf of the licensee.
- (4) "Bank" means an institution identified as a "bank" in 31 C.F.R. section 103.11.
- (5) "Board" means the Oklahoma State Banking Board.
- (6) "Commissioner" means the Oklahoma State Banking Commissioner.
- (7) "Control" means:
 - (A) ownership of, or the power to vote, directly or indirectly, at least 25 percent of a class of voting securities or voting interests of a licensee or person in control of a licensee;
 - (B) power to elect a majority of executive officers, managers, directors, trustees, or other persons exercising managerial authority of a licensee or person in control of a licensee; or
 - (C) the power to exercise directly or indirectly, a controlling influence over the management or policies of a licensee or person in control of a licensee.
- (8) "Department" means the Oklahoma State Banking Department.
- (9) "Executive officer" means a president, chairperson of the executive committee, chief financial officer, responsible individual, or other individual who performs similar functions.
- (10) "Licensee" means a person licensed under the Act. A licensee under this chapter is a "supplier" or "money transmitter" under section 2 of the Oklahoma Financial Transaction Reporting Act.
- (11) "Material litigation" means litigation that according to generally accepted accounting principles is significant to an applicant's or a licensee's financial health and would be required to be disclosed in the applicant's or licensee's annual audited financial statements, report to shareholders, or similar records.
- (12) "Money" means a medium of exchange that is authorized or adopted by the United States or a foreign government. The term includes a monetary unit of account established by an intergovernmental organization or by agreement between two or more governments.
- (13) "Money transmission" means receiving money for transmission of the money or the value of the money, by any means through a financial agency or institution, a Federal Reserve Bank or other facility of one or more Federal Reserve Banks, the Board of Governors of the Federal Reserve System or both, or any other electronic network by which money or its value may be transmitted. Money transmission does not include the business of selling or issuing checks that is required to be licensed under the Oklahoma Sale of Checks Act, Title 6 O.S. § 2101 et seq.

- (14) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, government; governmental subdivision, agency or instrumentality; public corporation; or any other legal or commercial entity.
- (15) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.
- (16) "Responsible individual" means an individual who is employed by a licensee and has principal managerial authority over the provision of money transmission services by the licensee in this State.
- (17) "State" means a State of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.
- (18) "Unsafe or unsound practice" means a practice or conduct by a person licensed to engage in money transmission or an authorized delegate of such a person which creates the likelihood of material loss, insolvency, or dissipation of the licensee's assets, or otherwise materially prejudices the interests of its customers.

85:15-1-3. Exclusions

The Act does not apply to:

- (1) the United States or a department, agency, or instrumentality thereof;
- (2) money transmission by the United States Postal Service or by a contractor on behalf of the United States Postal Service;
- (3) a state, county, city, or any other governmental agency or governmental subdivision of a State;
- (4) a Bank;
- (5) electronic funds transfer of governmental benefits for a federal, state, county, or governmental agency by a contractor on behalf of the United States or a department, agency, or instrumentality thereof, or a State or governmental subdivision, agency, or instrumentality thereof;
- (6) a board of trade designated as a contract market under the federal Commodity Exchange Act [7 U.S.C. Section 1-25 (1994)] or a person that, in the ordinary course of business, provides clearance and settlement services for a board of trade to the extent of its operation as or for such a board;
- (7) a registered futures commission merchant under the federal commodities laws to the extent of its operation as such a merchant;
- (8) a person that provides clearance or settlement services pursuant to a registration as a clearing agency or an exemption from such registration granted under the federal securities laws to the extent of its operation as such a provider;
- (9) an operator of a payment system to the extent that it provides processing, clearing, or settlement services, between or among persons excluded by this section, in connection with wire transfers, credit card transactions,

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debit card transactions, stored-value transactions, automated clearing house transfers, or similar funds transfers;
or
(10) a person registered as a securities broker-dealer under federal or state securities laws to the extent of its operation as such a broker-dealer.

SUBCHAPTER 3. MONEY TRANSMISSION LICENSES

85:15-3-1. License required

(a) A person may not engage in the business of money transmission or advertise, solicit, or hold itself out as providing money transmission unless the person:

- (1) is licensed under the Act; or
- (2) is an authorized delegate of a person licensed under the Act.

(b) A license under the Act is not transferable or assignable.

85:15-3-2. Application for license

(a) A person applying for a license under the Act shall do so in a form and in a medium prescribed by the Commissioner. The application may require the following information:

- (1) the legal name and residential and business addresses of the applicant and any fictitious or trade name used by the applicant in conducting its business;
- (2) a list of any criminal convictions of the applicant and any material litigation in which the applicant has been involved in the 5-year period next preceding the submission of the application;
- (3) a description of all money transmission services currently provided anywhere by the applicant and the money transmission services that the applicant seeks to provide in this State;
- (4) a list of the applicant's proposed authorized delegates and the locations in this State where the applicant and its authorized delegates propose to engage in money transmission;
- (5) a list of other States in which the applicant is licensed to engage in money transmission and any license revocations, suspensions, or other disciplinary action taken against the applicant in another State during the previous 10-year period;
- (6) information concerning any bankruptcy or receivership proceedings affecting the licensee during the previous 10-year period;
- (7) a sample form of contract for authorized delegates;
- (8) a description of the source of money and credit to be used by the applicant to provide money transmission services; and
- (9) any other information the Commissioner reasonably requires with respect to the applicant.

(b) If an applicant is a corporation, limited liability company, partnership, or other entity, the applicant shall also provide:

(1) the date of the applicant's incorporation or formation and State or country of incorporation or formation;

(2) if applicable, a certificate of good standing from the State or country in which the applicant is incorporated or formed;

(3) a brief description of the structure or organization of the applicant, including any parent or subsidiary of the applicant, and whether any parent or subsidiary is publicly traded;

(4) the legal name, any fictitious or trade name, all business and residential addresses, and the employment, in the 5-year period next preceding the submission of the application of each executive officer, manager, director, or person that has control, of the applicant;

(5) a list of any criminal convictions and material litigation in which any executive officer, manager, director, or person in control of, the applicant has been involved in the 10-year period next preceding the submission of the application;

(6) a copy of the applicant's audited financial statements for the most recent fiscal year and, if available, for the two-year period next preceding the submission of the application;

(7) a copy of the applicant's unconsolidated financial statements for the current fiscal year, whether audited or not, and, if available, for the two-year period next preceding the submission of the application;

(8) if the applicant is publicly traded, a copy of the most recent report filed with the United States Securities and Exchange Commission under Section 13 of the federal Securities Exchange Act of 1934 [15 U.S.C. Section 78m (1994 & Supp. V 1999)];

(9) if the applicant is a wholly owned subsidiary of:

(A) a corporation publicly traded in the United States, a copy of audited financial statements for the parent corporation for the most recent fiscal year or a copy of the parent corporation's most recent report filed under Section 13 of the federal Securities Exchange Act of 1934 [15 U.S.C. Section 78m (1994 & Supp. V 1999)]; or

(B) a corporation publicly traded outside the United States, a copy of similar documentation filed with the regulator of the parent corporation's domicile outside the United States;

(10) if the applicant has a registered agent in this State, the name and address of the applicant's registered agent in this State; and

(11) any other information the Commissioner reasonably requires with respect to the applicant.

(c) A nonrefundable application fee of \$3,000, a license fee of \$2,000, and \$50 per authorized delegate must accompany an application for a license under the Act. The license fee and authorized delegate fees will be refunded if the application is denied.

(d) The Commissioner may waive one or more requirements of subsections (a) and (b) or permit an applicant to submit other information in lieu of the required information.

85:15-3-3. Security

- (a) A surety bond, letter of credit, or other similar security acceptable to the Commissioner in the amount of \$50,000 plus \$10,000 per location of each authorized delegate, not exceeding a total of \$500,000, must accompany an application for a license. The issuer of the security must be authorized to do business in this state and in good standing under Oklahoma law (if applicable) and the law of its state of organization.
- (b) Security must be in a form satisfactory to the Commissioner and payable to the Department for the benefit of (1) any claimant against the licensee and/or its authorized delegates to secure the faithful performance of the obligations of the licensee with respect to money transmission; and (2) any costs, expenses, and fees (including attorneys fees) incurred by the Department in connection with enforcement of the Act with respect to the licensee and its authorized delegates.
- (c) The aggregate liability on a surety bond may not exceed the principal sum of the bond. A claimant against a licensee may maintain an action on the bond, or the Commissioner may maintain an action on behalf of the claimant and/or the Department.
- (d) A surety bond must cover claims for so long as the Commissioner specifies, but for at least five years after the licensee ceases to provide money transmission services in this State. However, the Commissioner may permit the amount of security to be reduced or eliminated before the expiration of that time to the extent the amount of the licensee's obligations outstanding in this State is reduced. The Commissioner may permit a licensee to substitute another form of security acceptable to the Commissioner for the security effective at the time the licensee ceases to provide money services in this State.
- (e) The Commissioner may increase the amount of security required to a maximum of \$1,000,000 if the financial condition of a licensee so requires, as evidenced by reduction of net worth, financial losses, or other relevant criteria.

85:15-3-4. Issuance of license

- (a) When an application is filed under the Act, the Commissioner shall investigate the applicant's financial condition and responsibility, financial and business experience, character, and general fitness. The Commissioner may conduct an on-site investigation of the applicant, the cost of which the applicant must pay. The amount charged the applicant shall be the same as charged under subsection B. of section 2113 of Title 6 of the Oklahoma Statutes. The Commissioner shall issue a license to an applicant under the Act if the Commissioner finds that all of the following conditions have been fulfilled:
 - (1) the applicant has complied with sections 85:15-3-2, 85:15-3-3, and 85:15-3-6 of this subchapter; and
 - (2) the financial condition and responsibility, financial and business experience, competence, character, and general fitness of the applicant; and the competence, experience, character, and general fitness of the executive officers, managers, directors, and persons in control of, the applicant indicate that it is in the interest of the public to permit the applicant to engage in money transmission;
- (b) When an application for an original license under the Act is complete, the Commissioner shall promptly notify the

applicant in a record of the date on which the application was determined to be complete and:

- (1) the Commissioner shall approve or deny the application within 120 days after that date; or
- (2) if the application is not approved or denied within 120 days after that date:
 - (A) the application is approved; and
 - (B) the license takes effect as of the first business day after expiration of the 120-day period.
- (c) The Commissioner may for good cause extend the application period.
- (d) An applicant whose application is denied by the Commissioner under the Act may appeal, within 30 days after receipt of the notice of the denial, from the denial and request a hearing before the Board. A hearing is not required in order for the Commissioner to initially deny a license application.

85:15-3-5. Renewal of license

- (a) A licensee shall pay an annual renewal fee of \$2,000 plus \$50 per authorized delegate existing as of December 31 of each year. The fees shall be due no later than January 31 of each year. If a license is first issued to the licensee on or after October 1, the license shall be effective for the year of issuance and the next calendar year without a requirement to pay renewal fees or file a renewal report on the first January after issuance.
- (b) A licensee shall submit a renewal report with the renewal fee, in a form and in a medium prescribed by the Commissioner. The renewal report must state or contain:
 - (1) a copy of the licensee's most recent audited annual financial statement or, if the licensee is a wholly owned subsidiary of another corporation, the most recent audited consolidated annual financial statement of the parent corporation or the licensee's most recent audited consolidated annual financial statement;
 - (2) a description of each material change in information submitted by the licensee in its original license application which has not been reported to the Commissioner on any required report;
 - (3) a list of the licensee's permissible investments and a certification that the licensee continues to maintain permissible investments according to the requirements set forth in the Act;
 - (4) proof that the licensee continues to maintain adequate security as required by this Chapter; and
 - (5) a list of the locations in this State where the licensee or authorized delegates of the licensee engages in money transmission.
- (c) If a licensee does not file a renewal report and pay its renewal fees by the renewal date or any extension of time granted by the Commissioner, the Commissioner shall send the licensee a notice of suspension. Unless the licensee files the report and pays the renewal fees before expiration of 10 days after the notice is sent, the licensee's license is suspended 10 days after the Commissioner sends the notice of suspension. The suspension will be lifted if, within 20 days after its license is suspended, the licensee:
 - (1) files the report and pays all renewal fees; and

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(2) pays \$100 for each day after suspension that the Commissioner did not receive the renewal report and the renewal fees.

(d) If the licensee fails to file its renewal report and pay all fees (including the fee imposed under (2) of this subsection), the licensee's license will automatically expire and the person must reapply for a license under the Act and must then pay all applicable fees (including fees imposed under (2) of this subsection). No administrative hearing is required for suspension or expiration of licenses under the provisions of this section.

(e) The Commissioner for good cause may grant an extension of the renewal date.

85:15-3-6. Net worth

Each licensee under the Act shall at all times maintain a minimum net worth of at least Two Hundred Seventy-five Thousand Dollars (\$275,000.00) in order to engage in money transmission at one (1) to fifty (50) locations, Five Hundred Thousand Dollars (\$500,000.00) in order to engage in money transmission at fifty-one (51) to three hundred (300) locations, One Million Five Hundred Thousand Dollars (\$1,500,000.00) in order to engage in money transmission at three hundred one (301) to eight hundred (800) locations, or Three Million Dollars (\$3,000,000.00) in order to engage in money transmission at over eight hundred (800) locations. Net worth must be demonstrated annually by filing with the Commissioner, at the time of application for a license and at each time of license renewal, the most current annual audited financial statement of the licensee certified by a licensed public accountant holding a permit to practice in this state or by a certified public accountant. For purposes of this section, a financial statement shall be deemed to be current if it is no more than twelve (12) months old. Financial statements may be submitted to the Commissioner at any time in order to maintain a current status. The Commissioner may require, upon request, a more current statement than the last statement submitted by the licensee.

SUBCHAPTER 5. AUTHORIZED DELEGATES

85:15-5-1. Relationship between licensee and authorized delegate

(a) In this section, "remit" means to make direct payments of money to a licensee or its representative authorized to receive money or to deposit money in a bank in an account specified by the licensee.

(b) A contract between a licensee and an authorized delegate must require the authorized delegate to operate in full compliance with the Act. The licensee shall furnish in a record to each authorized delegate policies and procedures sufficient for compliance with the Act.

(c) An authorized delegate shall remit all money owing to the licensee in accordance with the terms of the contract between the licensee and the authorized delegate.

(d) If a license is suspended or revoked or a licensee does not renew its license, the licensee must notify all authorized delegates of the licensee whose names are in a record filed with the

Commissioner of the suspension, revocation, or non-renewal. After notice is sent or publication is made, an authorized delegate shall immediately cease to provide money transmission services as a delegate of the licensee. The former licensee must submit proof to the Commissioner that all authorized delegates have been notified of the suspension, revocation, or non-renewal. If the former licensee fails to provide the required notice, the Commissioner may provide the notice and recover his costs and expenses from the bond or other security posted by the former licensee or may require reimbursement of costs and expenses before the person may obtain a new or reinstated license.

(e) An authorized delegate may not provide money transmission services outside the scope of activity permissible under the contract between the authorized delegate and the licensee, unless the authorized delegate holds its own license under the Act or other money transmission services laws. An authorized delegate of a licensee holds in trust for the benefit of the licensee all money net of fees received from money transmission.

(f) An authorized delegate may not use a subdelegate to conduct money transmission services on behalf of a licensee.

85:15-5-2. Unauthorized activities

A person may not provide money transmission on behalf of a person not licensed under the Act and this Chapter. A person that engages in that activity provides money transmission services to the same extent as if the person were a licensee, including penalties for violations of the Act and this Chapter.

SUBCHAPTER 7. EXAMINATIONS; REPORTS; RECORDS

85:15-7-1. Authority to conduct examinations

(a) The Commissioner, or another state agency authorized by the Commissioner, may conduct an examination of a licensee or of any of its authorized delegates upon 10 days' notice in a record to the licensee.

(b) The Commissioner, or another state agency authorized by the Commissioner, may examine a licensee or its authorized delegate, at any time, without notice, if the Commissioner or such other agency has reason to believe that the licensee or authorized delegate is engaging in an unsafe or unsound practice or has violated or is violating any state or federal money laundering or criminal law.

(c) If an on-site examination is necessary under subsections (a) or (b), the licensee shall pay the reasonable cost of the examination. The amount charged shall be the same as charged under subsection B. of section 2113 of Title 6 of the Oklahoma Statutes.

85:15-7-2. Cooperation

The Commissioner may consult and cooperate with other state money transmission services regulators in enforcing and administering the Act. They may jointly pursue examinations

and take other official action that they are otherwise empowered to take.

85:15-7-3. Reports

- (a) A licensee shall file with the Commissioner within 15 business days any material changes in information provided in a licensee's application as prescribed by the Commissioner.
- (b) A licensee shall file with the Commissioner within 30 days after the end of each calendar quarter a current list of all authorized delegates, and locations in this State where the licensee or an authorized delegate of the licensee provides money transmission. The Commissioner may prescribe the type of information and format by which the information shall be submitted for each location and authorized delegate.
- (c) A licensee shall file a report with the Commissioner within two business days after the licensee has reason to know of the occurrence any of the following events:
 - (1) the filing of a petition by or against the licensee under the United States Bankruptcy Code for bankruptcy or reorganization;
 - (2) the filing of a petition by or against the licensee for receivership, the commencement of any other judicial or administrative proceeding for its dissolution or reorganization, or the making of a general assignment for the benefit of its creditors;
 - (3) the commencement of a proceeding to revoke or suspend its license in a State or country in which the licensee engages in business or is licensed;
 - (4) the cancellation or other impairment of the licensee's bond or other security;
 - (5) a charge or conviction of the licensee or of an executive officer, manager, director, or person in control, of the licensee for a felony; or
 - (6) a charge or conviction of an authorized delegate for a felony.

85:15-7-4. Change of control

- (a) A licensee shall:
 - (1) give the Commissioner notice in a record of a proposed change of control within 15 days after learning of the proposed change of control;
 - (2) request approval of the acquisition; and
 - (3) submit a nonrefundable fee of \$3,000 with the notice.
- (b) After review of a request for approval under subsection (a), the Commissioner may require the licensee to provide additional information concerning the proposed persons in control of the licensee. The additional information must be limited to the same types required of the licensee or persons in control of the licensee as part of its original license or renewal application.
- (c) The Commissioner shall approve a request for change of control under subsection (a) if, after investigation, the Commissioner determines that the person or group of persons requesting approval has the competence, experience, character, and general fitness to operate the licensee or person in control

of the licensee in a lawful and proper manner and that the public interest will not be jeopardized by the change of control.

(d) When an application for a change of control under this Chapter is complete, the Commissioner shall notify the licensee in a record of the date on which the request was determined to be complete and:

- (1) the Commissioner shall approve or deny the request within 120 days after that date; or
- (2) if the request is not approved or denied within 120 days after that date:
 - (A) the request is deemed approved; and
 - (B) the Commissioner shall permit the change of control under this section, to take effect as of the first business day after expiration of the period.

(e) The Commissioner may exempt a person from any of the requirements of subsection (a) (2) and (3) if it is in the public interest to do so.

(f) Subsection (a) does not apply to a public offering of securities.

(g) Before filing a request for approval to acquire control of a licensee or person in control of a licensee, a person may request in a record a determination from the Commissioner as to whether the person would be considered a person in control of a licensee upon consummation of a proposed transaction. If the Commissioner determines that the person would not be a person in control of a licensee, the Commissioner shall enter an order to that effect and the proposed person and transaction are not subject to the requirements of subsections (a) through (c).

85:15-7-5. Records

- (a) A licensee shall maintain the following records for determining its compliance with the Act for at least three years:
 - (1) a general ledger posted at least monthly containing all asset, liability, capital, income, and expense accounts;
 - (2) bank statements and bank reconciliation records;
 - (3) a list of the last known names and addresses of all of the licensee's authorized delegates; and
 - (4) any other records the Commissioner reasonably requires.
- (b) Authorized delegates shall maintain the following records for at least three years:
 - (1) for each money transmission of \$1,000 or more, the records specified in 31 C.F.R. § 103.33(f);
 - (2) all documents required to be maintained or completed by the federal Bank Secrecy Act; and
 - (3) any other records the Commissioner reasonably requires.
- (c) The items specified in subsections (a) and (b) may be maintained in any form of record.
- (d) Records may be maintained outside this State if they are made accessible to the Commissioner on seven business-days' notice that is sent in a record.
- (e) All records maintained by the licensee and authorized delegates as required in subsections (a) through (d) are open to inspection by the Commissioner or the Commissioner's authorized representative, including another state agency authorized by the Commissioner.

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85:15-7-6. Money laundering reports

A licensee and all authorized delegates shall file all reports required by federal currency reporting, record keeping, and suspicious transaction reporting requirements as set forth in 31 U.S.C. Section 5311, 31 C.F.R. Part 103, and other federal and state laws pertaining to money laundering.

SUBCHAPTER 9. PERMISSIBLE INVESTMENTS

85:15-9-1. Maintenance of permissible investments

(a) A licensee shall maintain at all times permissible investments that have a market value computed in accordance with generally accepted accounting principles of not less than the aggregate amount of all of money transmitted from all states by the licensee.

(b) The Commissioner, with respect to any licensees, may limit the extent to which a type of investment within a class of permissible investments may be considered a permissible investment, except for money and certificates of deposit issued by a bank. The Commissioner may allow other types of investments that the Commissioner determines to have a safety substantially equivalent to other permissible investments.

85:15-9-2. Types of permissible investments

(a) Except to the extent otherwise limited by the Commissioner pursuant to Section 85:15-9-1, the following investments are permissible under Section 85:15-9-1:

(1) cash, a certificate of deposit, or senior debt obligation of an insured depository institution, as defined in the Federal Deposit Insurance Act;

(2) banker's acceptance or bill of exchange that is eligible for purchase upon endorsement by a member bank of the Federal Reserve System and is eligible for purchase by a Federal Reserve Bank;

(3) an investment bearing a rating of one of the three highest grades as defined by a nationally recognized organization that rates securities;

(4) an investment security that is an obligation of the United States or a department, agency, or instrumentality thereof; an investment in an obligation that is guaranteed fully as to principal and interest by the United States; or an investment in an obligation of a State or a governmental subdivision, agency, or instrumentality thereof;

(5) receivables that are payable to a licensee from its authorized delegates, in the ordinary course of business, pursuant to contracts which are not past due or doubtful of collection if the aggregate amount of receivables under this paragraph does not exceed 20 percent of the total permissible investments of a licensee and the licensee does not hold at one time receivables under this paragraph in any one person aggregating more than 10 percent of the licensee's total permissible investments; and

(6) a share or a certificate issued by an open-end management investment company that is registered with the United States Securities and Exchange Commission under

the Investment Companies Act of 1940, and whose portfolio is restricted by the management company's investment policy to investments specified in paragraphs (1) through (4).

(b) The following investments are permissible under Section 85:15-9-1, but only to the extent specified:

(1) an interest-bearing bill, note, bond, or debenture of a person whose equity shares are traded on a national securities exchange or on a national over-the-counter market, if the aggregate of investments under this paragraph does not exceed 20 percent of the total permissible investments of a licensee and the licensee does not at one time hold investments under this paragraph in any one person aggregating more than 10 percent of the licensee's total permissible investments;

(2) a share of a person traded on a national securities exchange or a national over-the-counter market or a share or a certificate issued by an open-end management investment company that is registered with the United States Securities and Exchange Commission under the Investment Companies Act of 1940, and whose portfolio is restricted by the management company's investment policy to shares of a person traded on a national securities exchange or a national over-the-counter market, if the aggregate of investments under this paragraph does not exceed 20 percent of the total permissible investments of a licensee and the licensee does not at one time hold investments in any one person aggregating more than 10 percent of the licensee's total permissible investments;

(3) a demand-borrowing agreement made to a corporation or a subsidiary of a corporation whose securities are traded on a national securities exchange if the aggregate of the amount of principal and interest outstanding under demand-borrowing agreements under this paragraph does not exceed 20 percent of the total permissible investments of a licensee and the licensee does not at one time hold principal and interest outstanding under demand-borrowing agreements under this paragraph with any one person aggregating more than 10 percent of the licensee's total permissible investments; and

(4) any other investment the Commissioner designates, to the extent specified by the Commissioner.

(c) The aggregate of investments under subsection (b) may not exceed 50 percent of the total permissible investments of a licensee calculated in accordance with Section 85:15-9-1.

SUBCHAPTER 11. ENFORCEMENT

85:15-11-1. Suspension and revocation

(a) The Commissioner may suspend or revoke a license or order a licensee to revoke the designation of an authorized delegate if:

(1) the licensee violates the Act;

(2) the licensee does not cooperate with an examination or investigation by the Commissioner or the Commissioner's designee;

- (3) the licensee engages in fraud, intentional misrepresentation, or gross negligence;
- (4) an authorized delegate is convicted of a violation of a state or federal anti-money laundering statute, or violates a rule adopted or an order issued under the Act, as a result of the licensee's willful misconduct or willful blindness;
- (5) the competence, experience, character, or general fitness of the licensee, authorized delegate, person in control of a licensee, or responsible person of the licensee or authorized delegate indicates that it is not in the public interest to permit the person to provide money services;
- (6) the licensee engages in an unsafe or unsound practice;
- (7) the licensee is insolvent, suspends payment of its obligations, or makes a general assignment for the benefit of its creditors;
- (8) the licensee does not remove an authorized delegate after the Commissioner issues and serves upon the licensee a final order including a finding that the authorized delegate has violated the Act; or
- (9) a material misstatement of fact in an initial or renewal application, the loss of license in another jurisdiction (due to fraud or dishonest dealing) and criminal convictions involving fraud or dishonest dealing as grounds for license denial, suspension or non-renewal.

(b) In determining whether a licensee is engaging in an unsafe or unsound practice, the Commissioner may consider the size and condition of the licensee's money transmission, the magnitude of the loss, the gravity of the violation of the Act, and the previous conduct of the person involved.

85:15-11-2. Suspension and revocation of authorized delegates

(a) The Commissioner may issue an order suspending or revoking the designation of an authorized delegate, if the Commissioner finds that:

- (1) the authorized delegate violated the Act or an order issued under the Act;
- (2) the authorized delegate did not cooperate with an examination or investigation by the Commissioner or the Commissioner's designee;
- (3) the authorized delegate engaged in fraud, intentional misrepresentation, or gross negligence;
- (4) the authorized delegate is charged with a violation of a state or federal anti-money laundering statute or other criminal statutes in connection with its money transmission;
- (5) the competence, experience, character, or general fitness of the authorized delegate or a person in control of the authorized delegate indicates that it is not in the public interest to permit the authorized delegate to provide money services; or
- (6) the authorized delegate is engaging in an unsafe or unsound practice.

(b) In determining whether an authorized delegate is engaging in an unsafe or unsound practice, the Commissioner may

consider the size and condition of the authorized delegate's provision of money services, the magnitude of the loss, the gravity of the violation of the Act, and the previous conduct of the authorized delegate.

(c) An authorized delegate may apply for relief from a suspension or revocation of designation as an authorized delegate according to procedures prescribed by the Commissioner.

85:15-11-3. Orders to cease and desist

(a) If the Commissioner determines that a violation of the Act or an order issued under the Act by a licensee or authorized delegate is likely to cause immediate and irreparable harm to the licensee, its customers, or the public as a result of the violation, or cause insolvency or significant dissipation of assets of the licensee, the Commissioner may issue an order requiring the licensee or authorized delegate to cease and desist from the violation. The order becomes effective upon service of it upon the licensee or authorized delegate.

(b) The Commissioner may issue an order against a licensee to cease and desist from providing money services through an authorized delegate that is the subject of a separate order by the Commissioner.

(c) An order to cease and desist remains effective and enforceable pending the completion of an administrative proceeding pursuant to sections 85:15-11-1 or 85:15-11-2.

(d) A licensee or an authorized delegate that is served with an order to cease and desist may petition the Oklahoma County District Court, for a judicial order setting aside, limiting, or suspending the enforcement, operation, or effectiveness of the order pending the completion of an administrative proceeding pursuant to sections 85:15-11-1 or 85:15-11-2.

(e) An order to cease and desist expires unless the Commissioner commences an administrative proceeding pursuant to sections 85:15-11-1 or 85:15-11-2 within 10 days after it is issued.

85:15-11-4. Consent orders

The Commissioner may enter into a consent order at any time with a person to resolve a matter arising under the Act or a rule adopted or order issued under the Act. A consent order must be signed by the person to whom it is issued or by the person's authorized representative, and must indicate agreement with the terms contained in the order. A consent order may provide that it does not constitute an admission by a person that the Act or an order issued under the Act has been violated.

85:15-11-5. Civil penalties

The Commissioner may assess a civil penalty against a person that violates the Act or an order issued under the Act in an amount not to exceed \$100 per day for each day the violation is outstanding, plus the State's costs and expenses for the investigation and prosecution of the matter, including reasonable attorney's fees.

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85:15-11-6. Hearings

Except as otherwise provided in the Act, the Commissioner may not suspend or revoke a license, suspend or revoke the designation of an authorized delegate, or assess a civil penalty without notice and an opportunity to be heard. The Commissioner shall also hold a hearing when requested to do so by an applicant whose application for a license is denied.

[OAR Docket #07-714; filed 4-5-07]

TITLE 175. STATE BOARD OF COSMETOLOGY CHAPTER 10. LICENSURE OF COSMETOLOGISTS, SCHOOLS AND RELATED ESTABLISHMENTS

[OAR Docket #07-686]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Licensure of Cosmetology Schools
Part 3. Student Registration and Entrance Requirements
175:10-3-16 [AMENDED]
Part 5. Equipment and Curriculum Requirements
175:10-3-31 [AMENDED]
175:10-3-34 [AMENDED]
175:10-3-37 [AMENDED]
175:10-3-38 [AMENDED]
175:10-3-41 [AMENDED]
175:10-3-43 [AMENDED]
Part 7. General Operations and Licensing Requirements
175:10-3-55 [AMENDED]
175:10-3-56 [AMENDED]
175:10-3-60 [AMENDED]
Subchapter 7. Sanitation and Safety Standards For Cosmetology
Establishments, Salons and Schools
175:10-7-28 [NEW]
Subchapter 9. Licensure of Cosmetologists and Related Occupations
Part 1. Apprenticeship
175:10-9-1 [AMENDED]
Part 3. State Board Examination
175:10-9-25 [AMENDED]
175:10-9-26 [AMENDED]
Subchapter 11. License Renewal, Fees and Penalties
175:10-11-2 [AMENDED]
Subchapter 13. Reciprocal and Crossover Licensing
175:10-13-1 [AMENDED]

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59 O.S., Section 199.3 (A); State Board of Cosmetology

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n/a

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n/a

ANALYSIS:

The Board adopted rules as deemed appropriate and necessary to further the purposes of the Cosmetology Act. House Bill 2527 was passed during the 2006 legislative session. The amendments in rules implement House Bill 2527 which provides for a \$10.00 annual license fee increase. The amendments and new rule also provide for general clean-up and clarification of rules an current Board policy.

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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTION 308.1 (A), WITH AN EFFECTIVE DATE
OF JULY 1, 2007:**

SUBCHAPTER 3. LICENSURE OF COSMETOLOGY SCHOOLS

PART 3. STUDENT REGISTRATION AND ENTRANCE REQUIREMENTS

175:10-3-16. Student entrance requirements

Student entrance requirements for the Basic Cosmetologist, Manicurist/Nail Technician, Cosmetician, Hairbraiding Technician and Esthetician/Facialist/Facial Operator courses are as follows:

(1) The student must:

(A) be at least 16 years of age by November 1st of the current year.

(B) submit completed student registration application accompanied by a fee of \$5.00 before attending classes.

(C) submit a copy of the completed student/school contract with the student registration application. The contract shall state cost of kit and how and when it is considered paid for and becomes the sole property of the student. If kit provision is a rental-depreciation or other agreement, contract will provide details of the agreement.

(D) submit proof of at least eighth grade education or equivalency or submit proof of having satisfactorily passed an ability to benefit exam.

(E) submit, if under 18 years of age, a photocopy of birth certificate or other legal proof of age.

(F) submit 2"X 3" current full-face photograph of the applicant as requested on registration form. A current photograph is one taken within the last six months.

- (2) Each student shall be registered with the State Board of Cosmetology before attending school.
- (3) Each student shall be provided with an approved textbook or manual upon commencing training.
- ~~(4)~~ Each student must be provided a kit with minimum content requirements before commencing clinic training.
- ~~(5)~~ All applicants who register with the Board as students or who apply for a cosmetology license will be considered without regard to race, sex, creed, color, religion, or national origin provided they have met all requirements of cosmetology law and rules of the Board. All students shall be considered for enrollment in a cosmetology school. Admission to public schools is governed by applicable state and federal laws.

PART 5. EQUIPMENT AND CURRICULUM REQUIREMENTS

175:10-3-31. Training equipment requirements

(a) The following minimum equipment is considered by the Board to be adequate for the appropriate and safe training of no more than thirty-seven (37) students. The minimum equipment shall be required for one (1) to and including thirty-seven (37) students.

- (1) One (1) school seal
- (2) One (1) Chart of Anatomy to include:
 - (A) bones
 - (B) muscles
 - (C) nerves
 - (D) circulatory system
 - (E) skin
- (3) One (1) blackboard
- (4) Three (3) large wet sanitizers (pan-type with covers)
- (5) One (1) large dry sanitizer with airtight cabinet (without fumigant) to keep instruments, combs, and brushes after they have been taken from wet sanitizer
- (6) One (1) small dry sanitizer for each student (closed dry cabinet, drawer or other covered box-type container)
- (7) One (1) container with cover for each student to store soiled brushes/combs etc. until such time as all items shall be cleaned and sanitized according to approved rules and methods
- (8) Four (4) shampoo basins equipped with shampoo sprays and connected with hot and cold water (one shampoo basin for each additional 15 students or major fraction thereof)
- (9) Four (4) shampoo chairs (one for each additional 15 students or major fraction thereof)
- (10) Two (2) facial chairs, considered adequate for patron service; reclining, styling or shampoo are acceptable for student practice (one for each additional 15 students or major fraction thereof)
- (11) One (1) facial supply cabinet (one for each additional 15 students or major fraction thereof)
- (12) One (1) therapeutic lamp with red lights installed for free use of hands.

- (13) Four (4) hair dryers - chair type (one for each additional 15 students or major fraction thereof)
- (14) Twelve (12) blow-dryers (one for each additional 15 students or major fraction thereof)
- (15) Twelve (12) curling irons (one for each additional 15 students or major fraction thereof)
- (16) One (1) mannequin for each student ~~Fifteen (15) mannequins (one for each additional 3 students)~~
- (17) Four hundred (400) permanent wave rods and other permanent wave supplies as necessary
- (18) Twenty (20) work/styling stations with mirrors (one for each additional 5 students)
- (19) Twenty (20) styling chairs (one for each additional 5 students)
- (20) Five (5) covered waste receptacles
- (21) One (1) large closed cabinet for clean towels
- (22) Four (4) large covered receptacles for soiled towels (one for each additional 15 students or major fraction thereof)
- (23) One (1) large dispensary cabinet
- (24) Four (4) manicure tables and chairs considered adequate for patron service. A long narrow (18") folding table is acceptable for student practice
- (25) One (1) covered hair pin or clippie container for each student
- (26) Subscriptions to at least three (3) professional cosmetology related periodicals
- (27) Four (4) heaters and irons
- (28) Five (5) head forms
- (29) Five (5) wefts

(b) Other additional equipment shall be required if the Board's Inspector shall show evidence that the need for additional equipment is necessary to the appropriate and safe training in all phases of cosmetology to each student enrolled in the school.

175:10-3-34. Basic Cosmetologist course curriculum for privately owned and public schools

(a) **Privately owned cosmetology school.** The 1500 clock hour or 50 credit hour curriculum (pure cosmetology) is prescribed as follows:

- (1) Theory (must be coordinated with each practical practice subject as is appropriate throughout the course of training)
 - (A) Clock hours - 150
 - (B) Credit hours - 5
- (2) Manicuring and pedicuring (including sculptured nails and tips and other artificial nail application procedures and care)
 - (A) Clock hours - 90
 - (B) Credit hours - 3
- (3) Facials (skin care training includes make-up, waxing and/or other methods for non-permanent ~~permanent~~ hair removal)
 - (A) Clock hours - 30
 - (B) Credit hours - 1
- (4) Scalp treatments
 - (A) Clock hours - 30

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- (B) Credit hours - 1
- (5) Shampooing/conditioning rinses
(A) Clock hours - 60
(B) Credit hours - 2
- (6) Hairstyling, including finger waving, the dressing of wigs, thermal and blow drying
(A) Clock hours - 390
(B) Credit hours - 13
- (7) Hair color tints and bleaching and other color treatments
(A) Clock hours - 120
(B) Credit hours - 4
- (8) Hair cutting and hair shaping with shears and thinning shears (scissors) razor and clipper (includes beard)
(A) Clock hours - 180
(B) Credit hours - 6
- (9) Lash and brow tinting and arching
(A) Clock hours - 30
(B) Credit hours - 1
- (10) Personality, shop management and unassigned hours for review, examinations, etc.
(A) Clock hours - 180
(B) Credit hours - 6
- (11) Hair restructuring/permanent waving and chemical hair relaxing
(A) Clock hours - 240
(B) Credit hours - 8
- (12) Total cosmetology hours
(A) Clock hours - 1500
(B) Credit hours - 50
- (b) **Public cosmetology school.** The 1500 clock hour or 50 credit hour curriculum (1000 hours pure cosmetology plus 500 hours of cosmetology related high school subjects) is prescribed for public school students only in the following situations:
- (1) Cosmetology students that are currently attending high school
- (2) Persons that did not otherwise complete their cosmetology training while registered as a cosmetology student in high school.
- (A) Students who shall qualify for training in this manner must complete by completing 1000 clock hours or 33 credit hours in a Basic cosmetology course and 500 hours of approved related subjects. The official high school transcript shall serve as documentation for the 500 hours of related instruction. The transcript must show passing grades in related subjects and completion of at least the first semester of the twelfth (12th) grade. Related subjects shall run concurrently with and shall be in no instance older than three (3) years at time of enrollment in a cosmetology school course. The curriculum as follows has a recommended completion time of two (2) school years.
- (B) Adult students registered in a cosmetology school are not eligible to train under the 1000 hours pure cosmetology plus 500 hours of cosmetology related high school subjects unless qualified under (b) (1) and (2) of this rule.
- (~~3~~4) Theory (must be coordinated with each practical practice subject as is appropriate throughout the course of training)
(A) Clock hours - 150
(B) Credit hours - 5
- (~~4~~2) Manicuring and pedicuring (including sculptured nails and tips and other artificial nail application procedures and care)
(A) Clock hours - 60
(B) Credit hours - 2
- (~~5~~3) Facials (skin care training includes make-up, waxing and/or other methods for non-permanent permanent hair removal)
(A) Clock hours - 30
(B) Credit hours - 1
- (~~6~~4) Scalp treatments
(A) Clock hours - 30
(B) Credit hours - 1
- (~~7~~5) Shampooing/conditioning rinses
(A) Clock hours - 30
(B) Credit hours - 1
- (~~8~~6) Hairstyling, including finger waving, the dressing of wigs, thermal and blow drying
(A) Clock hours - 180
(B) Credit hours - 6
- (~~9~~7) Hair color tints and bleaching and other color treatments
(A) Clock hours - 90
(B) Credit hours - 3
- (~~10~~8) Hair cutting and hair shaping with shears and thinning shears (scissors) razor and clipper (includes beard)
(A) Clock hours - 120
(B) Credit hours - 4
- (~~11~~9) Lash and brow tinting and arching
(A) Clock hours - 30
(B) Credit hours - 1
- (~~12~~10) Personality, shop management and unassigned hours for review, examinations, etc.
(A) Clock hours - 100
(B) Credit hours - 3
- (~~13~~11) Hair restructuring/permanent waving and chemical hair relaxing
(A) Clock hours - 180
(B) Credit hours - 6
- (~~14~~12) Cosmetology related subjects
(A) Clock hours - 500
(B) Credit hours - 17
- (~~15~~13) Total cosmetology hours
(A) Clock hours - 1500
(B) Credit hours - 50
- (c) **Minimum student kit contents for private and public schools.**
- (1) A Basic Cosmetology student kit minimum equipment is required as follows:
(A) one (1) approved text on theory of cosmetology

- (B) one (1) razor-type hair shaper and shaper blades or razor hone
 - (C) one (1) pair each hair cutting shears and thinning shears
 - (D) one (1) cuticle nipper for finger nails and one (1) nipper for toe nails
 - (E) one (1) cuticle scissors
 - (F) one (1) nail brush
 - (G) one (1) nail file or package of emery boards
 - (H) one (1) tweezer
 - (I) twelve (12) hair brushes
 - (J) twelve (12) hard rubber combs or other good quality combs (shall include rat-tail, color, regular and/or barber-type)
 - (K) two (2) boxes of curl clips (100 per box)
 - (L) one (1) shampoo cape
 - (M) twelve (12) dozen hair styling rollers
 - (N) one (1) kit or tray to contain student personal training equipment
- (2) In addition to the list of equipment in (1) of this Section the school shall immediately have available for student training:
- (A) appropriately sanitized set of manicuring implements for student training use on each patron
 - (B) toe nail clipper
 - (C) permanent wave rods
 - (D) other hair restructuring supplies
 - (E) an adequate supply of applicator bottles
 - (F) an adequate supply of protective gloves (disposable)
 - (G) an adequate supply of neck strips
 - (H) an adequate supply of hair clippers
 - (I) an adequately supplied products dispensary to appropriately train students in cosmetology classes
 - (J) visual aid equipment in addition to the chalk or marker board

175:10-3-37. Master instructor course entrance and curriculum requirements

- (a) **Entrance requirements.**
- (1) Student registered in the master instructor course must:
 - (A) hold an Oklahoma Cosmetologist license or be registered for the Basic Cosmetologist examination. If any person enrolled prior to examination shall fail to appear or fail to pass Basic Cosmetologist, he/she shall immediately cease master instructor training until such time as he shall again register for and show proof of achieving a passing score on the cosmetologist examination.
 - (B) hold a High School Diploma or General Education Development Certificate.
 - (C) file registration application for master instructor course including fee of \$5.00 with the Board.
 - (2) Each student shall be provided with an approved textbook or manual before commencing training.

(b) **Curriculum requirements.** The 1000 clock hour or ~~34~~ ~~33~~ credit hour Master Instructor course curriculum is prescribed as follows:

- (1) Orientation
 - (A) Clock hours - 60
 - (B) Credit hours - 2
- (2) Introduction to teaching and curriculum
 - (A) Clock hours - 120
 - (B) Credit hours - 4
- (3) Course outlining and development; lesson planning; teaching techniques; teaching aids; developing and administering and grading examinations
 - (A) Clock hours - 330
 - (B) Credit hours - 11
- (4) Cosmetology Law, cosmetology school management and record keeping
 - (A) Clock hours - 90
 - (B) Credit hours - 3
- (5) Teaching - assisting in the classroom and clinic
 - (A) Clock hours - 150
 - (B) Credit hours - 5
- (6) Practice teaching - classroom and clinic
 - (A) Clock hours - 250
 - (B) Credit hours - ~~9~~ ~~8~~
- (7) Total hours
 - (A) Clock hours - 1000
 - (B) Credit hours - ~~34~~ ~~33~~

(b) Master Instructor students are assigned practice in classes actually scheduled by the school. Practice teaching by master instructor students will be in the Basic, Manicurist/Nail Technician, Cosmetician, Hairbraiding Technician and/or Esthetician/Facialist/Facial Operator course. Practice teaching must be supervised by a licensed master instructor.

(c) A master instructor student is not allowed to perform patron services. The master instructor student shall only demonstrate for or otherwise assist student under his supervision.

(d) **Minimum student kit contents.** A master instructor minimum kit equipment is required as follows:

- (1) textbook or manual
- (2) workbook

175:10-3-38. Manicurist/Nail Technician course entrance and curriculum requirements

(a) **Entrance requirements.** Manicurist/nail technician course entrance requirements are the same as for a Basic course student.

- (1) Each student shall be provided an approved textbook before commencing classroom training.
- (2) A manicurist/nail technician student shall not be allowed to perform patron services until such time as he/she has received at least 80 clock hours or 2 credit hours of practice and classroom instruction under the direct supervision of a licensed instructor.
- (3) Kit is required on or before completion of classroom training.
- (4) If a licensed manicurist/nail technician registers for the Basic course, credit of 224 clock hours or 8 credit hours is allowed.

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(b) **Curriculum requirements.** The 600 clock hour or 20 credit hour curriculum is prescribed as follows:

- (1) Bacteriology, sterilization and sanitation
 - (A) Clock hours - 40
 - (B) Credit hours - 1
- (2) Nail structure, composition, disorders and diseases
 - (A) Clock hours - 60
 - (B) Credit hours - 2
- (3) Manicuring and pedicuring (includes waxing or other non-permanent hair removal)
 - (A) Clock hours - 160
 - (B) Credit hours - 6
- (4) Artificial nails
 - (A) Clock hours - 160
 - (B) Credit hours - 6
- (5) Nail art
 - (A) Clock hours - 60
 - (B) Credit hours - 2
- (6) Salon development (includes business administration and law; insurance; professional ethics; record keeping; business telephone techniques; salesmanship; displays and advertising; hygiene and public health)
 - (A) Clock hours - 80
 - (B) Credit hours - 2
- (7) Cosmetology law, rules and regulations
 - (A) Clock hours - 40
 - (B) Credit hours - 1
- (8) Total hours
 - (A) Clock hours - 600
 - (B) Credit hours - 20

(c) **Minimum student kit contents.**

- (1) A Manicurist/nail technician minimum kit equipment is required as follows:
 - (A) one (1) textbook or manual
 - (B) one (1) cuticle nipper for finger nails and one (1) nipper for toe nails
 - (C) one (1) cuticle scissor
 - (D) one (1) cuticle pusher
 - (E) one (1) nail brush
 - (F) one (1) nail file or package of emery boards
 - (G) artificial nail product and tools
 - (H) ~~G~~ one (1) kit or tray to contain student personal training equipment
- (2) In addition to the list of equipment in (1) of this subsection, the school shall have immediately available for student training:
 - (A) appropriately sanitized set of manicuring implements for student use on each patron
 - (B) an adequate supply of protective gloves (disposable)
 - (C) visual aid equipment in addition to the chalk or marker board

175:10-3-41. Cosmetician course entrance and curriculum requirements

(a) **Entrance requirements.** Cosmetician course entrance requirements are the same as for a Basic course.

(1) Each student shall be provided an approved textbook or manual before commencing classroom training.

(2) A Cosmetician student shall not be allowed to perform patron services until such time as he/she has received at least 80 clock hours or 2 credit hours of practice and classroom instruction under the direct supervision of a licensed.

(3) Kit is required on or before completion of practice and classroom instruction hours.

(4) If a licensed Cosmetician registers for the Basic course, credit of 224 clock hours or 8 credit hours is allowed.

(b) **Curriculum requirements.** The 600 clock hour or 20 credit hour curriculum is prescribed as follows:

- (1) Bacteriology, sterilization and sanitation
 - (A) Clock hours - 60
 - (B) Credit hours - 2
- (2) Make-up application (includes application of make-up, lipstick, eyeshadow, eyeliner, mascara and rouge)
 - (A) Clock hours - 200
 - (B) Credit hours - 7
- (3) Hair arranging (includes arranging of the hair using curling irons, hot rollers, combs, brushes and any necessary product and accessories)
 - (A) Clock hours - 200
 - (B) Credit hours - 7
- (4) Salon development (includes business administration and law, insurance, professional ethics, record keeping, business telephone techniques, salesmanship, displays, advertising, hygiene and public health)
 - (A) Clock hours - 90
 - (B) Credit hours - 3
- (5) Cosmetology rules, regulations and law
 - (A) Clock hours - 50
 - (B) Credit hours - 1
- (6) Total hours
 - (A) Clock hours - 600
 - (B) Credit hours - 20

(c) **Minimum student kit contents.**

(1) A Cosmetician minimum kit equipment is required as follows:

- (A) textbook or manual
- (B) make-up with disposable applicators
- (C) lipstick with disposable applicators
- (D) eyeshadow with disposable applicators
- (E) mascara with disposable applicators
- (F) eyeliner with disposable applicators
- (G) rouge/blush with disposable applicators
- (H) 1 set of five (5) make-up brushes
- (I) hairspray
- (J) minimum of twelve (12) combs
- (K) minimum of twelve (12) hairbrushes
- (L) disposable make-up sponges
- (M) hot rollers
- (N) curling iron
- (O) one (1) kit or tray to contain student personal training equipment

- (P) one (1) comb-out cape
- (2) In addition to the list of equipment in (1) of this subsection, the school shall have immediately available for student training:
 - (A) an adequate supply of protective gloves (disposable)
 - (B) an adequate supply of neck strips
 - (C) visual aid equipment in addition to the chalk or marker board ~~blackboard~~

175:10-3-43. Hairbraiding Technician course entrance and curriculum requirements

(a) **Entrance requirements.** Hairbraiding Technician course entrance requirements are the same as for a Basic course pursuant to OAC 175:10-3-16.

- (1) Each student shall be provided an approved textbook or manual before commencing classroom training.
- (2) A Hairbraiding Technician student shall not be allowed to perform patron services until such time as he/sh has received at least 80 clock hours or 2 credit hours of practice and classroom instruction under the direct supervision of a licensed Instructor.
- (3) Kit is required on or before completion of practice and classroom instruction hours.
- (4) If a licensed Hairbraiding Technician registers for the Basic course, credit of 224 clock hours or 8 credit hours is allowed.

(b) **Curriculum requirements.** The 600 clock hour or 20 credit hour curriculum is prescribed as follows:

- (1) Bacteriology, chemistry, sterilization and sanitation (includes hair and scalp disorders)
 - (A) Clock hours - 100
 - (B) Credit hours - 3
- (2) Hairbraiding/hairweaving skills (includes purpose and effect, procedures, repair, removal of weft, sizing and finishing, extension and maintenance/care of braids/weaves)
 - (A) Clock hours - 300
 - (B) Credit hours - 10
- (3) Salon development (includes business administration and law, insurance, professional ethics, record keeping, business telephone techniques, salesmanship, displays, advertising, hygiene and public health)
 - (A) Clock hours - 180
 - (B) Credit hours - 6
- (4) Cosmetology rules, regulations and law
 - (A) Clock hours - 30
 - (B) Credit hours - 1
- (5) ~~Total hours Cosmetology rules, regulations and law~~
 - (A) Clock hours - 600
 - (B) Credit hours - 20

(c) **Minimum student kit contents.**

- (1) A Hairbraiding Technician minimum kit equipment is required as follows:
 - (A) textbook or manual
 - (B) four (4) hair brushes

- (C) four (4) hard rubber combs or other good quality combs (shall include rat-tail, color, regular and/or barber type)
- (D) hair extension material
- (E) one (1) comb-out cape
- (F) ~~one (1) box of curl clips (100 per box) one (1) kit or tray to contain student personal training equipment~~
- (G) one (1) kit or tray to contain student personal training equipment

(2) In addition to the list of equipment in (1) of this subsection, the school shall have immediately available for student training:

- (A) an adequate supply of protective gloves (disposable)
- (B) an adequate supply of neck strips
- (C) visual aid equipment in addition to the chalk, marker board or acceptable alternative ~~blackboard~~.

PART 7. GENERAL OPERATIONS AND LICENSING REQUIREMENTS

175:10-3-55. Student application and contracts

- (a) A new student application, contract and other required documents must be submitted before student commences training in any course. Student registration form must contain all applicable information including social security information.
- (b) A student must be given a copy of the student contract at enrollment time.
- (c) A copy of each student/school contract must be kept on file in the school.
- (d) A student/school contract shall not be changed after a copy is submitted to the Board unless a change in contract is initialed by each involved party. A copy of the initialed contract shall be given to student at time of any change and a copy submitted to the Board within five (5) days of a change, noted with revised date.
- (e) A student shall be registered in only one cosmetology school at any given time.

175:10-3-56. Student training; approved credits; credit limits

- (a) **Commencement of student training.** Student training shall be counted from the date on the student registration receipt. The postmark will determine the issuance date on the student registration receipt. The postmark will determine the issuance date on the registration receipt provided that all forms and affidavits required by the Board are complete and accurate in accordance with Board rules. A student registration for any course in a specific school is valid two (2) years.
- (b) ~~If a cosmetology school offers both credit hours and~~ has an articulation agreement with a college or university, then the school shall notify a student prior to the student's registration of the following:
 - (1) the identity of the college or university with which the school has the agreement; and

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- (2) the number of credit hours that the college or university will accept pursuant to the articulation agreement.
- (c) The notice shall also include a disclaimer informing the student that there is no guarantee that colleges or universities that do not have an articulation agreement with the school will accept the credit hours. The notice to the student shall be prominently displayed in the student handbook.
- (d) **Direct instructor supervision required.** A student must train under the direct supervision of an instructor employed by the school at all times in order to be credited for hours by the Board.
- (e) **Credit for cosmetology related field trip.** A student may be given credit for hours spent in a Board approved cosmetology related field trip provided:
- (1) the student is accompanied and observed by a cosmetology instructor licensed by the State of Oklahoma.
 - (2) credit for cosmetology related field trips shall not exceed seventy-two (72) total clock hours of the Basic Cosmetology course or more than sixteen clock hours in a given week.
 - (3) credit for cosmetology related field trips shall not exceed twenty-four (24) total clock hours of the Manicurist, Facial/Esthetics or Hairbraiding Technician course or more than sixteen clock hours in a given week.
 - (4) credit for cosmetology related field trips shall not exceed forty (40) total clock hours of the Master Instructor, Manicurist/Nail Technician Instructor or Facial/Esthetics Instructor course or more than sixteen clock hours in a given week.
- (f) **Credit for model participation in a State Board practical examination.** A student may be given eight (8) clock hours for participation as a student model in a State Board practical examination.
- (g) **Credit limit per day.** No student is permitted to receive more than eight (8) clock hours per day.

175:10-3-60. Attendance and other records and requirements

- (a) **Minimum attendance per week.** A part time schedule shall be submitted and approved by the Board. Student shall attend a clock hour cosmetology school at least three (3) hours per day, five (5) days per week or a total of fifteen (15) hours per week.
- (b) **Daily sign-in/time clock or other records maintained in a clock hour school.** In addition to maintaining a current record of student hours, clock hour schools shall keep a record of daily attendance. Students registered in a clock hour school shall sign or clock in and out of each class daily.
- (c) **Credit hour records maintained in a credit hour school.** Credit hour schools shall maintain a current record of credit hours earned by each student ~~with dates and times of attendance.~~
- (d) **Practical practice records.** Clock and credit hour schools shall maintain a record of clinic practical practices and theory credit or clock hours earned by each student.
- (e) **Student hour record retention.** School shall retain records of students for three (3) years.

- (f) **Record availability.** All attendance and educational records shall be available during inspection or upon request of the Board as allowed under the Cosmetology Act.

SUBCHAPTER 5. LICENSURE OF COSMETOLOGY ESTABLISHMENTS

175:10-7-28. Product knowledge and procedures

All licensees shall be held individually liable for product knowledge. Maximum precautionary, safe, sanitary and appropriate preparation prior to service and application, as required by product label, shall be practiced at all times upon the public. For products that contain a requirement for a patch test, licensees may provide a consumer advisory that is clearly visible in the area of the application, or provide the client with a printed fact sheet with information that describes the label requirement for the patch test, or utilize a signed statement of release of liability regarding the patch test warning.

SUBCHAPTER 9. LICENSURE OF COSMETOLOGISTS AND RELATED OCCUPATIONS

175:10-9-1. Apprentice training

- (a) An apprentice must train under the direct supervision of a currently licensed mater instructor or an instructor that is licensed in the particular field of practice. Only a licensed instructor may train an apprentice in a cosmetology establishment. Only a Manicurist/Nail Technician Instructor may train a manicurist apprentice. Only a Facial/Esthetics Instructor may train a facialist apprentice. Only one (1) apprentice per establishment shall be approved to be trained at any given time.
- (b) A currently licensed instructor who wishes to train an apprentice shall make written application to the Board. The application shall include:
- (1) Proof of need affidavit from the proposed apprentice. Proof of need is considered by the Board to be proof of dire financial circumstances of the apprenticeship applicant or proof of lack of cosmetology training available within a reasonable distance of residence of apprentice applicant).
 - (2) Apprenticeship inspection fee of \$20.00 (includes purchase of Rules, Regulations and Law book, apprentice registration and inspection fee) is required.
- (c) An inspection will be made by the Board for approval of required equipment, textbooks, and theory tests.
- (d) An interview will be conducted with the instructor and the proposed apprentice to assure that both parties fully understand the apprenticeship program.
- (e) When all requirements are met, an equipment affidavit will be signed by the inspector and the instructor. Apprentice registration forms will be completed at time of inspection.
- (f) Equipment required to train an apprentice shall include:
- (1) One (1) facial chair (reclining styling or shampoo chairs are acceptable).

- (2) One (1) therapeutic lamp with red lights or unit that provides multi-lamp or light-heat treatment, installed for free use of both hands.
- (3) One (1) facial supply cabinet.
- (4) One (1) work/styling station.
- (5) One (1) mannequin.
- (6) Other cosmetology establishment equipment as shall be required for course of training.
- (g) Textbooks must be approved by the Board that adequately cover the prescribed curricula and prepares students for State Board testing. Other textbooks and reference material may be used to enhance the apprentice course.
- (h) Reference and other library equipment include:
 - (1) Standard Dictionary
 - (2) American Medical Dictionary
 - (3) Subscription to at least one (1) professional magazine
- (i) Entrance requirements for apprentice training:
 - (1) Apprenticeship must be approved by the Board before apprentice attends class.
 - (2) Apprentice must be at least sixteen (16) years of age.
 - (3) Apprentice must show proof of at least 8th grade education or equivalency (8th grade diploma or transcript). The Board may accept a statement from a school official who states, upon interview with applicant, that applicant has the equivalency of at least 8th grade potential and ability to learn.
 - (4) Apprentice must be able to benefit from instruction.
 - (5) Apprentice must submit copy of birth certificate or other legal proof of age if under the age of 18 years of age.
- (j) Minimum content requirements for an apprentice kit are the same as for students registered in a cosmetology school.
- (k) In addition to requirements of a kit, the apprentice shall have available for apprentice training:
 - (1) At least one set of appropriately sanitized manicuring implements immediately available for use on each patron
 - (2) Adequately supplied dispensary to appropriately train apprentice in cosmetology practices; and
 - (3) Visual aid equipment in addition to the chalk or marker board.
- (l) Apprentice training may be approved for all courses except Instructor. Apprentice training may be approved for courses of review when required for expired license.
- (m) The instructor shall not charge the apprentice for training. The instructor may charge for cosmetology services rendered by the apprentice while in apprentice training.
- (n) If the apprentice performs extra curricular work for the shop owner for compensation, the work shall in no way interfere with the eight (8) hours per day of training for an apprentice.
- (o) The instructor shall instruct the apprentice in all subjects as outlined in the curricula prescribed by the Board to be taught in a cosmetology school. The instructor shall give the apprentice weekly tests and a final examination in both the practical skills and theory work.

- (p) Apprenticeship training shall be under the direct supervision of the approved licensed instructor at all times.

PART 3. STATE BOARD EXAMINATION

- 175:10-9-25. Examination form; administration and content of Board examination; passing score; disability accommodations; grade release reports**
- (a) The examination application shall be completed to include the School Affidavit of completion of hours, ~~2" X 3" current full face photograph of the applicant~~ and the examination fee of fifteen dollars (\$15.00).
 - (b) The Board shall conduct examinations for license at such times as the Board shall consider necessary to reasonably accommodate applicants for the examination.
 - (c) Each applicant shall be required to take both written and practical portion of the State Board of Cosmetology examination.
 - (d) The written exam will test general knowledge of cosmetology. Textbooks approved by the Board will contain the subjects and examination questions and answers.
 - (e) The test for all instructor license examination candidates must include completion of student attendance record form, lesson plan preparation, class presentation and a written theory test and other cognate areas of teacher training. The instructor tests shall include questions pertaining to Oklahoma Cosmetology law and Board rules and regulations.
 - (f) ~~Each applicant is required to bring a model for the practical examination.~~ When a live model is used, The model must be at least sixteen (16) years of age ~~or older~~.
 - (g) Minimum passing grades, on each portion of the examination, are as follows:
 - (1) Basic Cosmetology Course - 75%
 - (2) Master Instructor Course - 85%
 - (3) Manicurist Course - 75%
 - (4) Esthetician Course - 75%
 - (5) Cosmetician Course - 75%
 - (6) Hairbraiding Technician - 75%
 - (7) Manicurist/Nail Technician Instructor - 85%
 - (8) Facial/Esthetics Instructor - 85%
 - (h) A Cosmetologist, Manicurist, Esthetician, Cosmetician, or Hairbraiding Technician, declaring a disability, defined by the American Disabilities Act (ADA) shall submit a written statement when requesting an oral examination or other special testing accommodation. Such needs identification and request for special accommodation must be made at time of student enrollment with the Board or at the earliest time possible during course of training.
 - (i) Validity of disability must be established by the submission of a statement from a licensed health care professional qualified to diagnose the disability.
 - (j) Instructor license examination candidate declaring a disability shall be provided a distraction free space, test schedule variation and/or extended time to complete the test.

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(k) State Board examination grades/scores will be provided to schools at least twice a year. The reports will be provided more frequently only as time and staff allows.

175:10-9-26. Pre-registration for Board examination

(a) Except in emergency circumstances, examination pre-registration will be recognized by the Board only as follows:

(1) Application for examination pre-registration ~~including with photo and fee is accompanied by~~ the School Affidavit, which ~~reflects shall reflect~~ the total accumulated hours of training as of the date of application and shall reflect that applicant lacks 100 clock hours or 3 credit hours less of training required for course completion.

(2) May of each year shall be considered the "school year end" for any pre-registration application for examination, therefore, April, May and June pre-registration eligibility is established.

(3) A work permit shall not be issued to an applicant who is pre-registered before completion of training.

(4) School is required to submit School Affidavit immediately upon final completion of hours in order that the Board may issue a license.

(b) A student instructor may apply for examination registration within 100 clock hours or 3 credit hours of completion of the Instructor course.

SUBCHAPTER 11. LICENSE RENEWAL, FEES AND PENALTIES

175:10-11-2. Cosmetology license and penalty fees

(a) The Board is authorized the following license and penalty fees:

- (1) Student/Apprentice registration - \$5.00
- (2) Examination registration - \$15.00
- (3) Cosmetology school license (initial) - \$400.00
- (4) Cosmetology school license (renewal) - \$125.00
- (5) Master Instructor license - ~~\$30.00~~ ~~\$20.00~~
- (6) Facial/Esthetics Instructor license - ~~\$30.00~~ ~~\$20.00~~
- (7) Manicurist/Nail Technician Instructor license - ~~\$30.00~~ ~~\$20.00~~
- (8) Basic Cosmetology license - ~~\$25.00~~ ~~\$15.00~~
- (9) Manicurist license - ~~\$25.00~~ ~~\$15.00~~
- (10) Esthetician license - ~~\$25.00~~ ~~\$15.00~~
- (11) Cosmetician license - ~~\$25.00~~ ~~\$15.00~~
- (12) Hairbraiding Technician license - ~~\$25.00~~ ~~\$15.00~~
- (13) Demonstrator license - \$20.00
- (14) Advanced Operator license (renewal only) - ~~\$25.00~~ ~~\$15.00~~
- (15) Cosmetology establishment license (initial) - ~~\$45.00~~ ~~\$35.00~~
- (16) Cosmetology salon establishment license (renewal) - ~~\$30.00~~
- (16) ~~Cosmetic studio license (initial)~~ - \$40.00
- (17) Cosmetic studio license (initial) - \$40.00

(17) ~~Cosmetology establishment/Cosmetic studio license (renewal)~~ - \$20.00

(18) Cosmetic studio license (renewal) - \$30.00

(19) Nail salon license (initial) - \$45.00

(20) Nail salon license (renewal) - \$30.00

(21) ~~18~~ Reciprocity license - \$30.00

(22) ~~19~~ Reciprocity transfer of hours processing fee from out-of-state - \$30.00

(23) ~~20~~ Duplicate license (in case of loss or destruction of original license and/or renewal application) - \$5.00

(24) ~~21~~ Notary Fee - \$1.00

(25) ~~22~~ Certification of Records - \$10.00

(b) The Board shall charge a penalty fee of ten dollars (\$10.00) for the renewal of any license delinquent ~~after from~~ two (2) months ~~of to one (1) year~~ after expiration date. This sub section also applies to any delinquent initial license application.

(c) All fees shall be submitted to the Board in the form of a cashier's check, money order or business check. Personal checks are not accepted by the Board.

SUBCHAPTER 13. RECIPROCAL AND CROSSOVER LICENSING

175:10-13-1. Reciprocal License requirements

The Board, in accordance with the Oklahoma Cosmetology Statutes 59 O.S. Section 199.13, has ruled to accept any applicant on a license for comparable license basis from any state in which the applicant has met the license requirements ~~and applicant has proof of continuously engaging in the practice for which license is applied for at least three (3) years prior to making application.~~

(1) The Board may issue a reciprocity license for ~~comparable~~ license without examination to any applicant who shall qualify and who shall submit the completed appropriate and required application and fees to the Board.

(A) The reciprocity license application shall be submitted on forms approved by the Board and shall include official certification of current license, training, testing, and education records from the applicable State Board.

(B) The application shall include the (first year) reciprocity license and process fee of sixty dollars (\$60.00) plus the cost of the Oklahoma Board's Rules, Regulations and Law book. (The \$30.00 processing fee and book cost are non-refundable.)

(C) The reciprocity application shall require that the applicant submit a current full-face photograph of ~~self himself~~ with the license application, (photo must be approximately 2" X 3" in size and shall have the applicant's name printed on the back).

(2) Any non-English speaking reciprocity licensee or transfer of hours applicant must contact the Board's office concerning requirements for licensing and transfer of hours. After all papers have been completed and necessary documents attached, the applicant for reciprocity license must make an appointment and appear personally

in the Board's office for an interview before reciprocity license may be considered. ~~If said applicant appears to be unable to read, write or speak English, he shall be required to demonstrate minimum proficiency in the English language by achieving a minimum score of sixty percent (60%) on the English Language Proficiency Evaluation Test administered by the ELS Language Center in Norman, Oklahoma, or other ELS Language Center as may be established in the State of Oklahoma before reciprocity licensure may be considered by the Board. The Board may administer an English Proficiency examination in the office of the Board at time of interview.~~

(3) The Board may retain the right to require that any applicant for the Oklahoma Instructor license shall register for the Oklahoma Board's Instructor examination and show proof of scoring no less than 85% (on each portion of the examination, written and practical) if at any time the applicant shall fail to show proof of at least equivalent of high school education or if other circumstances or irregular or unusual nature is reflected in Instructor reciprocity application.

(4) Reciprocity shall be is granted only to a currently licensed cosmetologist, nail technician, facialist, hair-braider, cosmetician, master instructor, nail technician instructor, or facialist instructor from a state that issues a license applicant, or in a state or foreign country where no license is issued, upon due proof of three (3) years of cosmetology experience which shall have been acquired immediately prior to submitting reciprocity application.

(5) Reciprocity shall not be granted to an applicant from a state or foreign country that does not issue a license unless the following requirements are met: In order for a reciprocity license to be issued by the Board the applicant must:

(A) Show proof of attending a cosmetology school in state or country show proof of having held an out of state cosmetology license with a good record up to the expiration date of the license.

(B) Submit reciprocity application for license.

(C) Submit registration for examination form and show proof of scoring no less than 75% (on each portion of the examination, written and practical). If applicant should fail the examination, applicant must show proof of no less than 120 review hours in an Oklahoma school before being eligible to re-register and sit for the Oklahoma State Board of Cosmetology examination again. (\$15.00 re-examination fee required). Applicant must then show proof of scoring no less than 75% (on each portion of the examination, written and practical) before being eligible for Oklahoma licensure by reciprocity submit fee of sixty dollars (\$60.00) plus cost of Rules, Regulations and Law Book, plus examination fee of \$15.00 (if applicable) and follow the procedure required for an Oklahoma Cosmetologist with current (or expired) license before a reciprocity license may be issued.

(D) Submit fee of sixty dollars (\$60.00) plus cost of Rules, Regulations and Law Book, plus examination fee of \$15.00.

(6) No temporary permit shall be issued to an out-of-state reciprocity applicant e Cosmetologist.

[OAR Docket #07-686; filed 4-4-07]

**TITLE 235. OKLAHOMA FUNERAL BOARD
CHAPTER 10. FUNERAL SERVICES
LICENSING**

[OAR Docket #07-654]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 13. Continuing Education
235:10-13-10 [AMENDED]
235:10-13-11 [AMENDED]
235:10-13-12 [AMENDED]
235:10-13-13 [AMENDED]
235:10-13-14 [AMENDED]

AUTHORITY:
Oklahoma Funeral Board;
Title 59 O.S. Section 396.17;
Title 75 O.S. Section 302(A)(1);
Title 75 O.S. Section 307

DATES:
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Failure of the Legislature to disapprove the rules resulted in approval on
March 27, 2007

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March 27, 2007

Effective:
May 11, 2007

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:
Subchapter 13. Continuing Education
235:10-13-10 [AMENDED]
235:10-13-11 [AMENDED]
235:10-13-12 [AMENDED]
235:10-13-13 [AMENDED]
235:10-13-14 [AMENDED]

Gubernatorial approval:
August 24, 2006

Register publication:
24 Ok Reg 26

Docket number:
06-1284

INCORPORATIONS BY REFERENCE:
n/a

ANALYSIS:
The adopted rules clarify the continuing education requirements and give exemptions to senior citizens and individuals who are licensed but no longer active in the profession but wish to continue to renew their license. This

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will minimize the shortage of funeral service professionals. The burden of complying with the continuing education requirements has resulted in senior citizens and individuals who are licensed but no longer active in the profession no longer renewing their licenses.

CONTACT PERSON:

Terry McEnany, Executive Director (405)522-1790

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 13. CONTINUING EDUCATION

235:10-13-10. Continuing education requirements

(a) Beginning July 1, 2006, and each year thereafter, each applicant for renewal of a funeral director or embalmer license in Oklahoma, shall submit the renewal fee and documentation as prescribed by the Board of each continuing education course the licensee attended during the year. Every licensed funeral director, and/or licensed embalmer, shall attend a minimum of six (6) ~~professional development units (P.D.U.)~~ contact hours during each calendar year before their annual license renewal. ~~For purposes of implementing the Board's continuing education requirements, one (1) P.D.U. contact hour shall be construed as 50 minutes of learning activity. Individuals licensed as both a funeral director and embalmer shall be required to complete a minimum of six (6) hours of P.D.U. each calendar year.~~

(b) ~~Each continuing education provider and course shall be approved by the Board based on criteria similar to those established by the Academy of Professional Funeral Service Practice (the Academy). In order to assist the Board in its review, the Board may contract with an individual or institution with extensive experience in accrediting continuing education providers and courses. Each continuing education provider and course shall be approved by the: Academy of Professional Funeral Service Practice (the Academy), the funeral licensing boards of Texas, Kansas, Arkansas, New Mexico, and Missouri, or by the Oklahoma Funeral Board based on criteria similar to those established by the Academy. Providers and courses approved by the Academy shall be presumptively approved by the Board. The Board may also approve providers and courses that have been approved by another state's funeral director and embalmer regulatory agency, provided, the state agency's criteria for reviewing continuing education providers and courses are substantially equivalent to the Board's criteria. The Board shall not charge duplicate fees to review provider applications or courses approved by the Academy or another states regulatory agency or the funeral licensing boards of Texas, Kansas, Arkansas, New Mexico, and Missouri.~~

(c) A licensee may not receive credit for repeating the same course during the same calendar year.

(d) Individuals issued original or reciprocal licenses shall complete the continuing education requirements in the first full

calendar year following the issuance of an original or reciprocal license.

~~(e) Every licensee, unless exempt, shall submit satisfactory proof of completion the Board's continuing education requirements with the license renewal application on the form prescribed by the Board.~~

235:10-13-11. Continuing education program approval

(a) The continuing education program provider must possess professional credentials appropriate to the subjects covered in the program, and the program must contain demonstrable educational content related to the practice of funeral directing and/or the practice of embalming as determined by the Board.

(b) The continuing education provider seeking Board approval shall ~~annually~~ pay a \$250 fee with ~~its initial application~~ the completed Uniform Continuing Education Application Process Form and \$50 per course submitted for Board approval. ~~The Board may waive the fees for governmental agencies and non-profit organizations. The provider shall submit its application, required documentation, and payment of fee(s) to and in the time and manner prescribed by the Board.~~ Providers shall submit the completed application and fees courses for Board ~~approval~~ evaluation at least sixty (60) days prior to administering the course.

(c) ~~Professional development units (P.D.U.)~~ Contact hours are not allowed for activities such as social occasions, meals, receptions, sporting events, business meetings, sales meetings, or exhibits displayed at such activities. If a provider wishes to offer a continuing education course at such an activity, then the provider shall be required to seek Board approval for that particular course. Continuing education received for renewal of an insurance license shall not qualify as ~~P.D.U. contact hours~~ for purposes of funeral director or embalmer license renewal.

(d) ~~Approved P.D.U.'s~~ contact hours may include programs in various formats such as: lecture, workshops, seminars, conferences, independent home study, and internet based programs. A continuing education program must fall within one or more of the following for categories of funeral service related content areas for approval:

(1) Public Health and Technical including: embalming, restorative art, etc.

(2) Business Management including computer applications, marketing, personnel management, accounting, or comparable subjects.

(3) Social Science including communications skills, both written and oral, sociological factors, counseling, grief psychology or comparable subjects.

(4) Legal, Ethical, Regulatory including: OSHA, FTC, ethical issues, legal interpretations or comparable subjects.

~~(e) Each Approved Provider shall provide the Board with a list of programs approved by the Board or the Academy, containing both course number and approved hours, for posting on the Board's website.~~

235:10-13-12. Exemptions

- (a) Licensees exempt from payment of renewal fees under 235:10-5-2 shall be exempt from all continuing education requirements for the first full calendar year after which they have completed their period of military service.
- (b) A licensee of Oklahoma ~~residing outside the state of Oklahoma and~~ not engaged in the practice of funeral directing or the practice of embalming within the State of Oklahoma shall be exempt from the Board's continuing education requirements. If the licensee becomes engaged in the practice of funeral directing or the practice of embalming within the State of Oklahoma, the licensee shall within the first full year of active practice meet the continuing education requirements.
- (c) Any licensee with a serious illness or disability shall notify the Board and request an exemption not less than thirty (30) days prior to the expiration of the license. The letter of request ~~with~~ must include documentation from the licensee's physician to verify the illness ~~and or~~ disability. The Board shall have the power to review the request for exemption of all or a portion of the Board's continuing education requirements on a case by case basis.
- (d) Licensees who will be 65 years of age or older anytime during the calendar year being renewed for are not required to meet the continuing education requirements. This exemption shall not apply to licensees who are the Funeral Director in Charge of one or more funeral establishments.

235:10-13-13. Verification of Continuing Education

- (a) Each licensee shall obtain from the continuing education provider proof of attendance at the approved continuing education program which shall include: name of attendee, provider name and provider number, event number, event date, program title, and contact hours attended. The licensee shall maintain such documentation for a period of not less than two (2) years.
- (~~b~~) ~~The licensee is responsible for ensuring that the continuing education program has been approved, and for providing proof of attendance to the Board, in such form as the Board shall prescribe, concerning the completion of continuing education requirements.~~
- (~~b~~) The Board or its authorized representatives may monitor, inspect, or review any approved continuing education activity, and upon evidence of significant variations in the program presented from the program approved, may disapprove any or all ~~portion~~ of the approved hours granted to the activity.

235:10-13-14. Non-compliance and sanctions

The Board shall not renew a licensee's funeral director or embalmer license if the licensee has not complied with the continuing education requirements, ~~unless exempt~~, until the required fees, late fees, and ~~past~~ continuing education requirements are met unless waived by the Board.

[OAR Docket #07-654; filed 4-4-07]

**TITLE 245. STATE BOARD OF LICENSURE FOR PROFESSIONAL ENGINEERS AND LAND SURVEYORS
CHAPTER 15. LICENSURE AND PRACTICE OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS**

[OAR Docket #07-607]

RULEMAKING ACTION:

Permanent Final Adoption

RULES:

- Subchapter 13. Minimum Standards for Land Surveying
- 245:15-13-1. Purpose; scope; applicability [AMENDED]
- 245:15-13-2. Minimum Standards [AMENDED]
- Subchapter 17. Licensee's Seal
- 245:15-17-2. Use of seal [AMENDED]

AUTHORITY:

Title 59 O.S. Sections 475.1 et seq; State Board of Licensure for Professional Engineers and Land Surveyors

DATES:

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March 2, 2007

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Failure of the Legislature to disapprove the rules resulted in approval on March 28, 2007

Final Adoption:

March 28, 2007

Effective:

May 11, 2007

ANALYSIS:

- The Board's purpose for these rule revisions is as follows:
 - Remove gender bias.
 - Clarifies requirements for Minimum Standards for the Practice of Land Surveying and Mortgage Inspection Reports
 - Clarifies requirements for signing and sealing prototypical design plans

CONTACT PERSON:

Kathy Hart, Executive Director, (405) 521-2874

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 13. MINIMUM STANDARDS FOR THE PRACTICE OF LAND SURVEYING

245:15-13-1. Purpose; scope; applicability

In order to better serve the public in regulating the practice of land surveying in Oklahoma, these minimum standards of practice are established to achieve no less than minimum standard degrees of accuracy, completeness, and quality so

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as to assure adequate and defensible real property boundary locations. When more stringent survey standards than those set forth herein are required by ~~federal, state, or local government agencies~~, the survey shall comply with both those standards and with the Oklahoma Minimum Standards for the Practice of Land Surveying. Where the Professional Land Surveyor elects to follow or use a more thorough method of determining accuracy, it is not the intent of these standards to interfere. Land Surveyors failing to comply with or meet these minimum standards will be subject to disciplinary action by the Board.

245:15-13-2. Minimum Standards

(a) **Definitions:** as used in these standards, the following terms shall have the following meanings where the context permits as provided in 59 O.S. 471.1 et seq and Chapter 245:15-1-3 of the Rules of the Board.

(b) **Research and investigation.** Every property boundary survey shall be made in accordance with the boundary description, as provided to or as created by the surveyor, as nearly as is practicable. The surveyor, prior to making a survey, shall acquire available necessary survey data, which may include record descriptions, deeds, maps, abstracts of title, section corner ties, government notes, subdivision plats, road records, and other available section and boundary line location data in the vicinity. The surveyor shall analyze the data and make careful determination of the record title boundary of the property to be surveyed. From the information gathered, the surveyor, ~~or those working under their his agents under his direct control and personal supervision~~, shall search thoroughly for all controlling corners and all other available field evidence of boundary location ~~investigate possible parcel evidence supporting positions of obliterated control monuments and take necessary statements.~~

(c) **Minimum technical standards for land or boundary surveys (field and office).**

(1) In order for a plat, subdivision plat, map, or sketch of a survey to be acceptable in terms of this rule, it must be complete and shall be certified or otherwise stated as meeting these minimum technical standards.

(2) All measurements made in the field shall be in accordance with the United States Standard, using either US Survey Feet or meters. All measurements shall be referenced to the horizontal or vertical plane, with the exception of geodetic surveys.

(3) All survey drawings shall bear the name, address, telephone number, certificate of authorization number and expiration date of the Certificate of Authorization of the firm issuing the drawing, along with the name, license number, seal, signature, and date of signature of the surveyor.

(4) All survey drawings must bear the date of the last site visit and bear the date of any revisions thereon. If the site visit was performed on multiple dates, the drawing may specify the range of those dates.

(5) A designated north arrow and scale of the map shall be shown prominently upon the drawing.

(6) Any symbols and/or abbreviations representing physical objects used on the drawing will be clearly noted upon the drawing.

(7) A reference to all bearings shown must be clearly stated, i.e., whether to 'True North'; 'Grid North as established by state plane datum'; 'Assumed North based on the bearing of a well established line'; a 'Deed call for a particular line'; or 'the bearing of a particular line shown upon a plat'; etc.

(8) **Referencing surveys.**

(A) Surveys based on the United States Public Land Survey System shall be referenced to original or properly restored corners. The appropriate Bureau of Land Management Manual of Surveying instructions shall be used as a guide for the restoration of lost or obliterated corners and subdivision of sections into aliquot parts.

(B) Lot surveys within platted subdivisions shall be referenced to existing corner monuments within the subdivision as necessary to verify the survey.

(9) Where evidence of inconsistencies is found, such as overlapping descriptions, hiatuses, excess or deficiency, or conflicting boundary line or monuments; the nature of the inconsistencies shall be shown on the drawing.

~~(10) All changes in direction, including curves, shall be shown on the drawing by angles, bearings or azimuths. Curved lines with circular curves shall show: 1. The radius; 2. Arc distance; and 3. Central angle, or chord distance and chord bearing. When lines are non tangent to a curve, sufficient angular data shall be shown to relate the line to the curve.~~

(10) All survey drawings shall show the change in direction between lines, lines and curves, and between adjacent curves, by angles, bearings or azimuths. Circular curves shall show: 1. The length of radius; 2. The arc distance; and 3. The chord distance and chord bearing. Sufficient information must be shown to mathematically close all lots and/or parcels.

(11) All easements and rights-of-way drawn or referenced on recorded subdivision plats on or across the land being surveyed shall be shown upon the survey drawing. If location of easements or rights-of-way, other than those drawn or referenced on recorded subdivision plats is required, this information must be furnished to the surveyor.

(12) The land surveyor shall establish or confirm a monument or confirm the prior placement of monuments at each and every property corner on the boundary line or boundary lines of the parcel or tract of land being surveyed. In such cases where the placement of a required monument at its proper location is impractical, a witness or reference monument shall be placed with the data given to show its location upon the ground in relation to the boundary lines or corner. In any case all monuments, either found or set, will be shown on the drawing. Where practical, monuments shall be constructed of material capable of being detected with the conventional instruments for finding ferrous or magnetic objects. Such monuments shall have affixed thereto a durable marker or cap bearing,

at a minimum, the license number of the land surveyor in responsible charge, or the certificate of authorization number of the firm performing the survey.

(13) The accuracy of the measurements for the survey shall be based upon the type of survey, and the current or expected use of the land. The accuracy of the measurements thus performed shall be substantiated by the computations of the traverse; the relative error of closure permissible shall be no greater than the following standards given below:

(A) Where there is or will be zero lot line construction on small tracts in a high density urban area, the allowable closure error is 1:10,000 and the allowable positional error is plus or minus 0.10 feet.

(B) In residential or commercial subdivisions where the length of lines does not exceed 300 ft, the area of tracts does not exceed 2 acres, and there is no plan for zero lot line construction, the allowable closure error is 1:10,000 and the allowable positional error is plus or minus 0.25 feet.

(C) In suburban or rural residential or industrial tracts where the length of lines does not exceed 1000 feet and the area of tracts is between 2 and 40 acres, the allowable closure error is 1:7,500 and the allowable positional error is plus or minus 0.50 feet.

(D) Rural tracts of 40 acres or more where the corners of the tract may be connected with traverse legs in excess of 1000 feet, the allowable closure error is 1:7,500 and the allowable positional error is plus or minus 1.5 feet.

(E) Rural tracts of 40 acres or more in rough or tree covered terrain where the corners of the tract must be connected with short traverse lines because of poor visibility between the corners of the tract, the allowable closure error is 1:5,000 and the allowable positional error is plus or minus 3.0 feet.

(F) Field work which has a closure error greater than the maximum allowed, or linear error of closure greater than the maximum positional error shown, shall be considered unacceptable and shall be corrected. Adjustment of a traverse must not shift the position of any point more than the maximum positional error listed above.

(G) In lieu of maximum allowable positional error, the latest Accuracy Standards for ALTA/ACSM Land Title Surveys may be used for determining minimum accuracy requirements.

(14) When special conditions exist that effectively prevent the survey from meeting these minimum standards, the special conditions and any necessary deviation from the standards shall be noted upon the drawing. It shall be a violation of this rule to use special conditions to circumvent the intent and purpose of these minimum standards.

(15) A survey plat, sketch or map must be created at any time a new parcel of land is created by a field survey, or if there are inconsistencies between an existing legal description and evidence found on the ground. In any event, every survey plat, sketch or map must contain the

legal description of the land being surveyed, either on the face of the survey plat or attached to and referenced to the survey plat.

(16) Additions or deletions to survey drawings by other than the signing party or parties is prohibited without written consent of the signing party or parties.

(d) **Minimum Standards for Property Descriptions.**

(1) All property descriptions prepared shall at a minimum contain the following items:

(A) A preamble containing the Quarter Section, Section, Township, Range, Principle Meridian (Indian or Cimarron) and the County and/ or City of the tract of land being described or a preamble containing the Lot and/or Block number, subdivision name and the county in which it is filed of record, and

(B) A beginning point (if applicable) referenced to a point such as a section corner, quarter-section corner, sixteenth section corner, or a Lot/Block corner of a recorded subdivision, and

(C) Distances listed to the nearest hundredth of a foot (if surveyed), and

(D) Bearings or angles listed in degrees, minutes and seconds (if surveyed), and

(E) A reference to all bearings shown must be clearly stated, i.e., whether to "True North"; "Grid North as established by state plane datum"; "Assumed North based on the bearing of a well established line"; a "Deed call for a particular line"; or "the bearing of a particular line shown upon a plat", and

(F) Curved lines with circular curves shall show: ~~(1.)~~ Direction of the curve (right or left); ~~(2.)~~ The radius; ~~(3.)~~ Arc distance; ~~(4.)~~ and ~~4. chord~~ Chord distance and chord bearing-, and ~~When lines are non tangent to a curve, it shall be so stated and sufficient angular data shall be shown to relate the line to the curve, and~~

(G) The aliquot method of describing the property may be used in lieu of a metes and bounds description, and

(H) The name and license number of the professional surveyor who prepared the description, and

(I) The date of preparation of the property description.

(2) A written legal description of the surveyed tract of land must provide sufficient information to locate the property on the ground and distinctly set it apart from all adjoining properties.

(3) Each metes and bounds description must return to the Point of Beginning and close mathematically within the allowable closure error stated in this subchapter.

(e) **Mortgage inspection certificate—report.** A Professional Land Surveyor may, based upon ~~his—~~their general knowledge of land boundaries and monuments in a given area, prepare a Mortgage Inspection ~~Certificate Report~~ for the use of a specific client. Such ~~certificate—report~~ shall be prominently labeled 'Mortgage Inspection Certificate Report' and shall not be designated as or construed as being a Land or Boundary

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Survey, and the statement furnished on the ~~certificate~~ report shall be similar to the following form:

MORTGAGE INSPECTION ~~CERTIFICATE~~ REPORT

~~"I hereby certify that this~~ This Mortgage Inspection ~~Certificate~~ Report was prepared for ... (individual or firm) ..., ~~that it is not a land or boundary survey plat, and that it is not to be relied upon for the establishment of fence, building or other future improvement lines. The accompanying sketch is a true representation of the conditions that were found at the time of the inspection, and the linear and angular values shown on the sketch, if any, are based on record or deed information and have not been verified unless noted."~~

~~I further certify that the improvements on the above described parcel, on this date (date), except utility connections, are entirely within the parcel, except as shown, that there are no encroachments upon the described premises by improvements on any adjoining premises, except as indicated, and that there is no apparent evidence or sign of any easement crossing or burdening any part of said parcel, except as noted." Any further statements shall be made only after proper research, investigation and boundary analysis is conducted per 245:15-13-2(a) through (d).~~

SUBCHAPTER 17. LICENSEE'S SEAL

245:15-17-2. Use of seal

(a) The application of the licensee's signature and date of signature to a sealed document shall constitute certification that the work thereon was done by the licensee or under the licensee's responsible charge and that the licensee accepts full responsibility and liability for the professional work represented thereon. Authorized use of the prescribed seal is an individual act. The licensee is responsible for its security at all times. The licensee shall permit no other person, firm, or entity to use the prescribed seal. The seal shall be affixed to documents and instruments only during the time the licensee's license is current and in good standing.

(b) Licensees must affix their seal, signature and date of signature to drawings which reflect work for which the licensee has responsible charge, including revisions and addenda thereto. In the case when multiple licensees are involved, each sheet in a set of drawings shall contain the seal, signature and date of the licensee responsible. Also, a licensee not practicing as a firm shall also include contact information to include address and phone number.

(c) In the case of bound documents, licensees must affix their seal, signature and date of signature to the cover sheet or index page, which identifies all documents bound together for which the licensee has responsible charge. In the absence of covers and index pages each document must have the seal, and dated signature of the licensee who has responsible charge. For bound documents involving multiple licensees, either each

document in the bound set must be sealed, signed and dated by the licensee in responsible charge for that portion of the work, or the cover sheet or index page must be sealed, signed and dated by each licensee with a breakdown of the licensee in responsible charge of each document clearly identified.

(d) In the case when the work consists of a letter or report prepared by a single licensee, the licensee need only seal, sign and date the first page, title page or signature page of the document.

(e) The Statute, 59 O.S., Sections 475.1 et seq. and Rules of the Board in this Chapter describe the use of the seal of the licensee. The seal, signature and date of signature shall be placed on all final engineering and land surveying documents. In lieu of sealing, signing and dating each copy of the work, the seal, signature and date shall be placed on originals, tracings, or other reproducible documents by the licensee in such a manner that when the originals, tracings, or other reproducible documents are reproduced the seal, signature and date will be legible.

(f) Work of a preliminary nature, submitted to obtain comments and not for formal approval, shall be clearly marked with the following statement: "This document is preliminary in nature and is not a final, signed and sealed document".

(g) An Engineer Intern or Land Surveyor Intern shall not have a seal.

(h) In circumstances where a licensee in responsible charge of the work is unavailable by reason of incapacity or death to complete the work, ~~or the work is a site adaptation of a standard design plan,~~ a successor licensee may take responsible charge ~~over, and complete the work, in accordance with the provisions of this Chapter. By performing all professional services to include developing a complete design file with work or design criteria, calculations, code research, and any necessary and appropriate changes to the work.~~ A licensee shall perform or have responsible charge over all professional engineering services to include development of a complete design file including work or design criteria, calculations, code research, and any necessary and appropriate changes to the work. The burden is on the successor licensee to demonstrate such compliance. The non-professional services, such as drafting, need not be redone by the successor licensee but must clearly and accurately reflect the successor licensee's professional work. The licensee shall have direct control and personal supervision over the engineering work and the signed, dated, and sealed originals of all documents over which the licensee has taken responsible charge under this provision.

(i) A licensee may take responsible charge over a standard, prototypical design plan, including drawings and specifications in printed or electronic form, for the purpose of adapting the plan to a specific site in this state, provided the licensee's work is completed in accordance with the provisions of this Chapter. This provision shall apply to both site adaptation of new structures and site adaptation for construction in an existing structure. In the case of an existing structure, the engineering for modifications to the existing structure and any of its systems shall be under the responsible charge of persons licensed in this state. Standard, prototypical designs that may

be site adapted under this provision are drawings and specification documents prepared for the purpose of defining the Owner's requirements but not yet completed for construction on a specific site. Site adaptation shall not include, and this provision does not authorize, a licensee to take responsible charge over work designed for construction on a specific site in this state that was prepared by a person not licensed in this state. Standard prototypical design plans shall not be released publicly or submitted to a client or user unless the plans are marked with a statement substantially equivalent to 'This document is preliminary in nature and is not a final, signed and sealed document'. The statement shall not be removed until an Oklahoma licensee has taken responsible charge of the work and the work is dated and issued under the seal and signature of an Oklahoma licensee. A licensee shall perform or have responsible charge over all professional engineering services to include development of a complete design file including work or design criteria, calculations, code research, and any necessary and appropriate changes to the work. The burden is on the successor licensee to demonstrate such compliance. The non-professional services, such as drafting, need not be redone by the successor licensee but must clearly and accurately reflect the successor licensee's professional work. The burden is on the successor licensee to show such compliance.—The successor licensee shall have direct control and personal supervision over of and responsibility for the engineering and/or surveying work and the signed, dated, and sealed originals of all documents over which the licensee has taken responsible charge under this provision.

(j) Record drawings prepared to reflect changes made during construction based on the record of changes made to construction drawings and changes to the construction observed by the licensee or on the licensee's behalf or reported by contractors is deemed a drafting service and shall not require a licensee's seal, signature, and date of signature.

(k) In the case of a firm, each separate document, the first page of a bound document, and, in the case of multiple licensees, the portion of the work for which each firm is responsible, shall also show the name of the firm, the firm's Certificate of Authorization number, and the renewal date of the Certificate of Authorization.

[OAR Docket #07-607; filed 3-30-07]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 531. VISION SCREENING

[OAR Docket #07-691]

RULEMAKING ACTION:
PERMANENT adoption

- RULES:**
Subchapter 1. General Provisions [NEW]
310:531-1-1 through 310:531-1-3 [NEW]
Subchapter 3. Advisory Committee [NEW]
310:531-3-1 through 310:531-3-3 [NEW]
Subchapter 5. Vision Screening Standards for Children [NEW]
310:531-5-1 through 310:531-5-3 [NEW]

AUTHORITY:

Oklahoma State Board of Health; 70 O.S. § 1210.284; 63 O.S. §§ 1-105 and 1-106 et seq.

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n/a

INCORPORATION BY REFERENCE:

n/a

ANALYSIS:

The proposed rule will implement the Oklahoma Vision Screening Act, 70 O.S. § 1210.284; that is focused on increasing the number of elementary school age children who have received a vision screening. The rule establishes the Oklahoma Vision Screening Advisory Committee for Children, guidelines and protocols for screening, standards for screeners and a statewide registry of qualified vision screening providers.

CONTACT PERSON:

Suzanna Dooley, MS, ARNP, Chief of Maternal and Child Health Service, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1299.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A); WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

310:531-1-1. Purpose

This chapter identifies the authority and provides definitions for vision screening services provided to elementary school age children by qualified vision screeners.

310:531-1-2. Authority

Oklahoma State Board of Health; 70 O.S. § 1210.284; 63 O.S. §§ 1-105 and 1-106 et seq.

310:531-1-3. Definitions

"Advisory Committee" means the Oklahoma Vision Screening Advisory Committee for Children.

"Board" means the State Board of Health.

"Commissioner" means the Commissioner of Health of the Oklahoma State Department of Health.

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"Department" means the Oklahoma State Department of Health.

"HOTV Chart" means a vision screening test that determines relative visual acuity for distance vision using a chart with the four (4) letters, H, O, T and V.

"Lea Symbol Chart" means a vision screening test that determines relative visual acuity for distance vision using a chart with the four (4) symbols, circle, square, house, and apple.

"Ophthalmologist" means a person licensed by the state of Oklahoma to practice medicine who has a specialty in ophthalmology.

"Optometrist" means a person licensed by the state of Oklahoma to practice optometry.

"Random Dot E Stereo Test" means a vision screening test that determines relative stereoacuity or depth perception.

"Snellen Letter Chart" means a vision screening test that determines relative visual acuity for distance vision using a chart consisting of eight (8) or more rows of progressively smaller block type letters.

"Vision Screening" means the process or system used to identify children in grades K, 1 and 3 who may be at risk of having or developing visual problems that may adversely affect their ability to acquire knowledge, skill or learning, for the purpose of recommending further evaluation by an eye care professional.

SUBCHAPTER 3. ADVISORY COMMITTEE

310:531-3-1. Purpose

This chapter creates the Oklahoma Vision Screening Advisory Committee for Children.

310:531-3-2. Advisory Committee

(a) The Advisory Committee shall consist of five (5) members who shall be appointed by the Commissioner.

(b) The Advisory Committee is comprised of one licensed optometrist, one licensed ophthalmologist, one representative of the State Department of Education, one representative of the Oklahoma State Department of Health, and one representative of a statewide organization for the prevention of blindness.

(c) The first Advisory Committee shall serve the following terms: one member for one (1) year, two members for two (2) years, and two members for three (3) years. Thereafter, at the expiration of the term of each member, the Commissioner shall appoint a successor for a four (4) year term.

(d) Vacancies occurring in the Advisory Committee shall be filled for the remainder of the term by appointment by the Commissioner.

(e) Any Advisory Committee member may be removed by the Commissioner for incapacity, incompetence, neglect of duty, or misfeasance or malfeasance in office.

(f) Advisory Committee members may be reappointed at the completion of their term.

(g) The Advisory Committee will hold a minimum of one regular meeting annually, and special meetings as needed.

Meetings shall be held at such time and place as the Advisory Committee may provide. The Advisory Committee shall elect annually the following officers: A chair, a vice-chair, and a secretary. Three members of the Advisory Committee shall constitute a quorum.

310:531-3-3. Rules of Order

Roberts Rules of Order Revised shall be the basis of parliamentary decisions except as otherwise provided by the Advisory Committee.

SUBCHAPTER 5. VISION SCREENING STANDARDS FOR CHILDREN

310:531-5-1. Purpose

This chapter identifies those children to be screened and standards for screening tools and vision screening providers.

310:531-5-2. Oklahoma Vision Screening Standards

(a) Parents or guardians of any child subject to the Oklahoma School Code shall provide certification of vision screening for any child who is:

(1) in Kindergarten, and the vision screening shall be completed within the previous twelve (12) months or during the school year;

(2) in the First grade, and the vision screening shall be completed within the previous (12) months, with certification provided to school personnel within thirty (30) days of the beginning of the school year; and

(3) in the Third grade, and the vision screening shall be completed within the previous twelve (12) months, with certification provided to school personnel within thirty (30) days of the beginning of the school year.

(b) Vision screening must, at a minimum, utilize the following vision screening tests using standard screening procedures:

(1) For relative distance acuity, the Snellen Letter Chart, HOTV Chart, or Lea Symbol Chart, at a distance of ten (10) feet;

(2) For stereoacuity, the Random Dot E Stereo Test, at a distance according to the calibration of the manufacturer; and,

(3) Any additional vision screening test recommended by the Advisory Committee and approved by the Commissioner of Health.

(c) The following visual criteria shall be used as a basis for referring a child for further evaluation by an eye care professional:

(1) For relative distance acuity, worse than 20/40 in either or both eyes for children below the First Grade, or worse than 20/30 in either or both eyes for children in the First grade or above, and for all children, a two or more line difference between either eye; and,

(2) For relative stereoacuity, a child identifies the E correctly in less than four (4) consecutive responses out of ten (10) attempts.

310:531-5-3. Vision Screening Provider Standards and Procedures

(a) To become a qualified vision screener, an organization or individual may make application to the Advisory Committee and include documentation of completion of training approved by the Advisory Committee that includes the following:

- (1) common eye problems;
- (2) the screening process;
- (3) required screening tools;
- (4) screening special populations; and,
- (5) basic anatomy and physiology of the eye.

(b) The Advisory Committee will review and submit, a minimum of one time annually, a list of qualified vision screening providers to the Department.

(c) All approved vision screening providers will be added to the statewide registry on the Internet website maintained by the Department.

[OAR Docket #07-691; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

[OAR Docket #07-710]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

317:2-1-2 [AMENDED]

317:2-1-5 [AMENDED]

(Reference APA WF # 06-34)

AUTHORITY:

Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

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317:2-1-2 [AMENDED]

317:2-1-5 [AMENDED]

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24 Ok Reg 300

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06-1437

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rules are revised to provide a more timely and efficient administrative appeals process. When a recipient is denied prior approval of a procedure, service, or durable medical equipment, he/she has the right to an administrative appeal. Current rules require an administrative appeal first be reviewed by a three person program panel (which may or may not contact the recipient prior to rendering a decision). If the denial is upheld, the recipient may then request a fair hearing before an Administrative Law Judge. The panel review may sometimes delay new information being reviewed by Agency staff, such as when a provider submits new information and a panel review has been scheduled, the new information may not be considered until the review. A review of the current process does not show a change in agency decision making nor does it reduce the agency's ability to properly consider administrative appeals. Revisions are needed to remove potential delays in the appeals process that may postpone a recipient's receipt of medically necessary procedures, services or durable medical equipment by eliminating the three person program staff review.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

317:2-1-2. Appeals

(a) Recipient Member Process Overview.

(1) The appeals process allows a ~~recipient member~~ recipient member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the ~~recipient member~~ recipient member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal).

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) ~~Recipient appeals are first reviewed by a three person program panel that may or may not contact the recipient [Section OAC 317:2-1-5]. The recipient may then request a fair hearing before the ALJ. Upon receipt of the~~

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member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The ~~recipient member~~ must appear at this hearing and it is conducted according to Section OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).

(7) ~~Recipient Member~~ appeals are to be decided within 90 days from the date OHCA receives the ~~recipient's~~ member's timely request for a fair hearing of the ~~program panel's decision~~ unless the ~~recipient member~~ waives this requirement. [Title 42 U.S.C. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) Provider Process Overview.

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(D) A decision will be rendered by the ALJ within 45 days of the close of all evidence in the case.

(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) ~~Recipient Member~~ Appeals:

(A) Discrimination complaints regarding the Medicaid program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered

by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to ~~dis-enroll~~ disenroll ~~recipient member~~ from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Petitions for Rulemaking;

(E) Appeals of insureds participating in O-EPIC which are authorized by OAC 317:45-9-8(a);

(F) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5, ~~317:10-1-13, 317:25-1-5, 317:25-1-12,~~ and other appeal rights granted by contract;

(G) Drug rebate appeals;

(H) Nursing home contracts which are terminated, denied, or non-renewed; and

(I) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.

317:2-1-5. Hearing procedures

~~(a) Program Panel Hearings. Program Panel Hearings will be by a Program Panel, except in the case of tax warrant intercept appeals and proposed administrative sanction appeals [refer to OAC 317:2-1-2(c)].~~

~~(1) The Program Panel will be composed of three or more members selected by the ALJ.~~

~~(2) The Program Panel may conduct a paper review of the complaint, or, at their option, hold a personal interview with the appellant to discuss the complaint. The Panel has the power to gather information it finds necessary from any available source, and thereafter, render a decision.~~

~~(3) The Panel must complete their paper review or conduct their formal personal interview and issue a majority decision within 25 days of the date stamped on the request for hearing.~~

~~(4) The Panel's decision will be in writing and will be signed by each of the Panel members. The decision will contain a summary of the complaint and an explanation of the reasoning of the Panel in making their decision. A copy of the decision will be sent to the member outlining~~

~~the right to appeal the decision. Any appeal of the Panel decision must be instituted within 20 days of the mailing of the adverse ruling.~~

~~(5) A copy of the decision will be forwarded to the docket clerk.~~

~~(6) Appeal from a decision of the Program Panel will be heard by the Administrative Law Judge. A decision will be rendered by the Administrative Law Judge within forty days of the appeal to the ALJ.~~

(b) Administrative Law Judge.

(1) Hearings will be conducted in an informal manner without formal rules of evidence or procedure.

(2) No party is required to be represented by an attorney. Recipients Members may represent themselves or authorize another party to represent them. A person or entity desiring to represent a recipient member must provide documentation of the consent of the recipient member to be represented by that person or entity. An appeal will be rejected without documentation of representation. Individuals appearing for corporate entities will be deemed to be authorized to represent the corporation in a hearing.

(3) The docket clerk will send the Appellant and any other necessary party notice which states the hearing hearing location, date, and time.

(4) The OHCA Administrative Law Judge or designee may:

- (A) Rule on any requests for extension of time;
- (B) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;
- (C) Require the parties to state their positions concerning the various issues in the proceeding;
- (D) Require the parties to produce for examination those relevant witnesses and documents under their control;
- (E) Rule on motions and other procedural items;
- (F) Regulate the course of the hearing and conduct of the participants;
- (G) Establish time limits for the submission of motions or memoranda;
- (H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:
 - (i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;
 - (ii) Excluding all testimony of an unresponsive or evasive witness; or
 - (iii) Expelling the person from further participation in the hearing;
- (I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;
- (J) Administer oaths or affirmations;
- (K) Determine the location of the hearing;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Reconsider or rehear a matter for good cause shown; and

(P) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

(5) The burden of proof during the hearing will be upon the appellant and the ALJ will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court. Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(6) Parties may file preliminary motions in the case. Any such motions must be filed within 15 calendar days prior to the hearing date. Response to preliminary motions must be made within 7 calendar days of the date the motion is filed with OHCA. Preliminary motions will be ruled upon 3 days prior to the hearing date.

(7) In any case in which a recipient member requests a continuance, OHCA will not be prejudiced to complete the case within 90 days.

[OAR Docket #07-710; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 10. PURCHASING**

[OAR Docket #07-693]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- 317:10-1-1 through 317:10-1-5 [AMENDED]
 - 317:10-1-7 [AMENDED]
 - 317:10-1-9 through 317:10-1-12 [AMENDED]
 - 317:10-1-15 through 317:10-1-20 [AMENDED]
- (Reference APA WF # 06-04)**

AUTHORITY:

Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Title 74, Section 85.5; Title 74, Section 85.1 through 85.45K

DATES:

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February 9, 2007

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February 9, 2007

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February 9, 2007

Permanent Final Adoptions

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317:10-1-1 through 317:10-1-5 [AMENDED]

317:10-1-7 [AMENDED]

317:10-1-9 through 317:10-1-12 [AMENDED]

317:10-1-15 through 317:10-1-20 [AMENDED]

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Purchasing rules are revised to provide clarity and authorize the use of agency purchase cards. State statute permits the use of purchase cards by state agencies in lieu of purchase orders. The use of a purchase card system will be beneficial to the agency by reducing staff time needed to complete and process purchase orders. Definitions, procedures, and terms are updated to comply with language in the Oklahoma Central Purchasing Act. Revisions are needed to provide clarity and authorize the use of agency purchase cards.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

317:10-1-1. Purpose

The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the ~~Oklahoma Health Care Authority OHCA~~. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the ~~Oklahoma Health Care Authority OHCA~~. These rules are superseded by the Oklahoma Department of Central Services (DCS) Purchasing rules (OAC 580:15) whenever DCS has final authority on an acquisition.

317:10-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Acquisition" means all types of purchases and rentals necessary to perform the duties assigned to the ~~Oklahoma Health Care Authority OHCA~~, whether bought or leased by contract or otherwise, and includes every means by which the ~~Oklahoma Health Care Authority OHCA~~ obtains any materials, supplies, service or equipment.

"Associate director(s)" means the most senior agency administrative personnel directly below the Chief Executive Officer in the agency line of authority.

"Authority" means the Oklahoma Health Care Authority.

"Authority Board" means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the ~~Oklahoma Health Care Authority OHCA~~.

"Award" means when the Chief Executive Officer or designee and Certified Procurement Officer agree on a suitable vendor for a competitive bid solicitation and the Chief Executive Officer, Certified Procurement Officer or designee notifies the successful vendor.

"Best Value" means a method for bid award that uses criteria established by the Oklahoma Central Purchasing Act and outlined under 74 O.S., 1998, Section 85.2(2).

"Bid" is an offer a vendor submits in response to a solicitation.

"Certified Procurement Officer" or **"CPO"** means a state agency official authorized by the Director of the Central Purchasing Division, Oklahoma Department of Central Services to make acquisitions for a state agency.

"Chief Executive Officer" or **"CEO"** means the highest ranking administrator at the ~~Oklahoma Health Care Authority OHCA~~.

"Commodity code" means a group of like products or services.

"Contracts" means the Contracts Division of the ~~Oklahoma Health Care Authority OHCA~~.

"Division" means a division within the ~~Oklahoma Health Care Authority OHCA~~.

"EEOC" means Equal Employment Opportunity Commission.

"Equipment" means all personal property acquired for use by the ~~Oklahoma Health Care Authority OHCA~~ which is in the nature of a tool, device, or machine and shall be deemed to include all personal property used or consumed by the ~~Oklahoma Health Care Authority OHCA~~ which is not included within the category of materials and supplies.

"Goods" means products, material, supplies and includes all property except real property acquired by the ~~Oklahoma Health Care Authority OHCA~~.

"Invitation to Bid" or **"ITB"** means a document issued which describes the goods or services for which offers are being solicited type of solicitation a state agency or the State Purchasing Director sends to suppliers for submission of bids for acquisitions.

"Non-Professional" means services which are predominantly physical or manual in character and may involve the supplying of products.

"Professional services" means services which are predominantly advisory or intellectual in character, or involve support rather than supplying equipment, supplies or other merchandise. Professional services include services to support or improve agency policy development, decision making, management, administration, or the operation of management systems.

"Public agency" means

- (A) any political subdivision of the state;
- (B) any agency of the state government or of the United States;
- (C) each and every public trust of this state, whether such trust is a municipality, a county, or the State of Oklahoma except the Oklahoma Ordinance Works Authority;
- (D) any corporation organized not for profit pursuant to the provisions of the Oklahoma General Corporation Act, Section 1001 et seq. Of Title 18 of the Oklahoma Statutes; and
- (E) any political subdivision of another state.

"Purchasing" means the Purchasing Division of the ~~Oklahoma Health Care Authority~~ OHCA.

"Request for Proposal" or "RFP" means a type of solicitation a state agency or the State Purchasing Director provides to suppliers requesting submission of proposals for acquisitions.

"Request for Quotation" or "RFQ" means a simplified written or oral solicitation a state agency or the State Purchasing Director sends to suppliers requesting submission of a quote.

"Services" means labor rendered by a person to another as distinguished from providing tangible goods. It shall include any type of personal or professional service, employment or undertaking except the employment of regular officers and employees by a state agency or such extra seasonal help as is authorized by law and is regularly used.

"Solicitation" is a request from a state agency or the State Purchasing Director for a proposal and/or pricing for an acquisition. Solicitation shall be by invitation to bid, request for proposal or request for quotation.

"State Agency or agency" means any office, officer, bureau, board, counsel, court, commission, institution, unit, division, body or house of the executive or judicial branches of the state government, whether elected or appointed, excluding only municipalities, counties, and other governmental subdivisions of the state.

"Supplier" or "Vendor" means an individual or business entity that sells or desires to sell acquisitions to state agencies.

317:10-1-3. General contracting and purchasing provisions

(a) The Authority has the statutory authority to directly purchase or acquire goods, services or equipment in compliance with the provisions of the Oklahoma Central Purchasing Act, the ~~Oklahoma Minority Business Enterprise Assistance Act~~, State Use Committee, other statutory provisions and rules of the Central Purchasing Division, Oklahoma Department of Central Services, for state agency acquisitions.

(b) Goods, services and equipment for the Oklahoma Health Care Authority shall be acquired by one of the following methods and in accordance with the statutes of the State of Oklahoma:

- (1) Acquisition of products and/or services through mandatory statewide contracts, State Use Committee procurement schedule, scheduled acquisition or non-encumbered contracts.

(2) Purchases from ~~Oklahoma State Industries~~ or other governmental agencies.

(3) Acquisition of products and/or services through non-mandatory statewide contracts if the price does not exceed the purchase price the agency could pay in an open market acquisition.

(4) Direct purchase order for products and/or services ~~by purchase order or purchase card~~ to the vendor within the authorized dollar amounts and other limitations contained in this Chapter.

(5) Competitive ~~bid~~ solicitation of products and services by the Authority.

(6) Competitive ~~bid~~ solicitation of products or services by the Oklahoma Department of Central Services, Central Purchasing Division.

(7) Sole source acquisitions according to the procedure in OAC 317:10-1-15.

(8) Donations to the Authority.

(c) The goods, services and equipment shall meet the specifications required, be acquired in compliance with the Central Purchasing Act and be cost effective.

(d) Except for acquisitions requiring the approval of the Authority Board, the CEO or a designated associate director, a CPO, in consultation with the requesting division, shall evaluate bids based upon criteria outlined in the ~~ITB~~ solicitation, and shall document that evaluation.

(e) All amendments to any acquisition shall be initiated by the requesting division, but must be approved by the CEO, a designated associate director or a CPO.

317:10-1-4. Vendor registration

~~(a)~~ Any vendor wishing to do business with the Authority should be on the vendor bidder list maintained by the Central Purchasing Division of the Oklahoma Department of Central Services. Any vendor who wants to be on the bidder list must register with the Central Purchasing Division at the Oklahoma Department of Central Services to receive copies of ~~bids~~ solicitations for the commodities or services which the vendor wishes to sell. All vendors are eligible for consideration.

317:10-1-5. Reports of vendor non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services

(a) To ensure that vendors will perform in the best interest of the Authority, it is necessary to address problems in a swift and equitable manner for all concerned. In addition, varying degrees of vendor misconduct can cause irreparable harm to the Authority and its divisions. It is therefore recognized that penalties for poor vendor performance and/or violation of state statutes must be addressed. Reports of vendor non-compliance ~~will~~ may be reported by the Authority to the Central Purchasing Division, Oklahoma Department of Central Services.

(b) Reports of vendor non-compliance may be considered, but is not limited to, the following infractions:

- (1) Failure to perform pursuant to specifications on ~~an~~ ITB a solicitation.

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- (2) Failure on the part of the vendor to meet promised and/or required delivery dates and prices.
- (3) Delivery by the vendor of substitutes in lieu of the items(s) specified on the approved bid and/or purchase order.
- (4) Failure on the part of the vendor to meet EEOC and other requirements mandated by public legislation or the Authority Board.
- (5) Problems created by the vendor regarding incorrect or inappropriate billing adjustment for goods and/or services furnished.
- (6) Failure to support purchased products by not supplying necessary information, required maintenance and/or parts.

317:10-1-7. Submission of bids

- (a) If a vendor wishes to bid on the item(s) listed in ~~an~~ ITB a solicitation, the vendor shall complete the bid via the instructions provided with the ITB solicitation. It is the vendor's responsibility to read and understand the instructions and terms and conditions provided with the ~~invitation to bid solicitation~~. Failure to comply with the instructions and terms and conditions in the ITB solicitation may disqualify the bid as per OAC 317:10-1-11. Any questions should be directed to the Authority's appropriate CPO.
- (b) If the vendor does not wish to bid on the items, the vendor should fill in the vendor name, address, and write "No Bid" in the unit price column and return the bid solicitation to Contracts or Purchasing, whichever is appropriate.
- (c) It is the responsibility of the vendor to ensure delivery of a bid to the Authority at or prior to the designated time on the ITB solicitation. The agency will not be responsible for late bids.

317:10-1-9. Bid evaluations

- (a) After the bid opening, the appropriate Certified Procurement Officer will utilize a spread sheet referred to as the "bid evaluation sheet". A bid evaluation sheet will be completed for each ITB solicitation. The vendor's bid will be reviewed for compliance with the instructions, compliance with the terms and conditions, and for compliance with the bid as per OAC 317:10-1-10 and 317:10-1-11.
- (b) The bid evaluation sheet will be provided to the agency's division requesting the ITB solicitation for their evaluation.

317:10-1-10. Award of bid

- (a) The ITB solicitation, the bid evaluation sheet, and the literature and/or samples provided by the vendor will be forwarded to the requisitioning division. The division will review the information to determine compliance with the bid solicitation specifications. The division will make a ~~written~~ recommendation of award based on the information provided. The recommendation will be reviewed by Contracts or Purchasing to ensure compliance with all Authority rules, policies and procedures.
- (b) Contracts or Purchasing has the right to waive minor deficiencies or informalities in a bid provided that, in the CPO's

judgment, the best interest of the state would be served without prejudice to the rights of the other ~~bidder~~ bidder(s).

(c) Tie bids may develop between bidders. If these bidders are equal in price and all specifications, the award will be determined by a coin toss or by a series of coin tosses.

(d) If the ITB solicitation specifies that the bid evaluation criteria is lowest and best, the bid will be evaluated by applying the following criteria:

- (1) Lowest total purchase price. The bid price shall be a firm fixed price for each acquisition the ITB solicitation specifies for the duration of the contract period.
 - (2) Quality and reliability of the acquisition. Additional factors regarding the responsiveness of the bid and the responsibility of the bidder shall be considered.
 - (3) Consistency of the proposed solution with state agency objectives. The Authority shall determine if the bid meets the specifications of the ITB solicitation and determine the consistency with state agency planning documents and announced strategic direction.
- (e) The Authority reserves the right to implement criteria of "Best Value" in the bid award process as outlined in 74 O.S., 1998, Section 85.7, and pursuant to the provisions of the Oklahoma Department of Central Services, Rules of the Central Purchasing Division, OAC 580:15-4-11(h).
 - (~~f~~) ~~A differential of up to 5% will be allowed in the cost to a certified minority business which means any business that is properly certified as a minority business enterprise through the Minority Business Assistance Program as provided in 74 O.S. 1991, Sections 85.45 et seq.~~
 - (~~g~~) The Authority reserves the right to accept by item, group of items, or by the total bid, as specified in the ITB solicitation.
 - (~~h~~) The Authority reserves the right to reject in part or whole any bid.
 - (~~i~~) No award will be made if the Authority determines the lowest bid totals more than the money available for purchase or if the lowest bid exceeds the reasonable market price.
 - (~~j~~) The Authority will send a purchase order or a notice of award as acceptable notification of a valid and binding contract with a vendor.
 - (~~k~~) All awards will be made under the terms and conditions as outlined in OAC 317:10-1-11 and any additional terms and conditions as described in the ~~invitation to bid solicitation~~.
 - (~~l~~) The ITB solicitation together with the successful vendor's responsive bid shall constitute a binding contract and will be interpreted under Oklahoma Law.
 - (~~m~~) All ethics rules and laws related to conflicts of interest and doing business with public officials apply to any acquisition by the Authority.

317:10-1-11. Terms and conditions for acceptable bids

- (a) All bids submitted are subject to the Authority's policies and procedures and/or any special conditions and specifications listed in this Subchapter, and made part of the ITB solicitation.
- (b) Sealed bids will be opened by the appropriate Certified Procurement Officer at the time and date shown on the ITB solicitation.

(c) Bids received after the closing time will not be considered. Envelopes must contain only one bid, be sealed and the name and address of the bidder inserted in the upper left hand corner. The requisition number and closing date must appear on the face of the envelope.

(d) The bid shall be in strict conformity with the instructions to the bidder and shall be submitted on the approved form. The bid must be signed by an authorized representative of the bidder ~~and notarized~~. The ~~quotations bids~~ must be typewritten or written in ink, and corrections must be initialed by a representative of the vendor prior to the submission of the bid. Corrections made by correction fluid or by correctable type-writer ribbons will not be accepted unless initialed. Penciled bids will not be accepted.

(e) The non collusion affidavit form must be completed and returned ~~with the bid~~.

(f) The bid may be awarded on an all or none basis, by item or groups of items, as specified in the ~~ITB solicitation~~.

(g) All bidders must guarantee that the quoted unit price in a bid is correct.

(h) Acquisitions by the Authority are not subject to any sales tax or federal excise tax.

(i) Prices shall be bid F.O.B. ~~the Authority~~ and include packaging, handling, shipping, and delivery charges prepaid by the bidder, unless otherwise specified in the ~~ITB solicitation~~.

(j) The bidder shall deliver the merchandise or services as bid. Any deviation must be approved in writing with the Authority CEO, designated associate director or the appropriate CPO.

~~(k) If a preference is claimed under the Minority Business Assistance Program, the bidder shall so state and provide their certification number.~~

~~(k)~~ Any questions pertaining to the clarification of the ~~bid solicitation~~ shall be directed to the appropriate CPO.

~~(m)~~ Any manufacturer, trade names, brand names, information and/or catalog numbers listed in the specification are for information and are not intended to limit competition. The bidder may offer any brand which meets or exceeds the specification for any item(s). If the bid is based on equivalent products, the bidder shall indicate on the bid form the manufacturer's name and number. The alternate bid shall be accompanied with sketches, descriptive literature, and/or completed specifications. Samples of the alternate item(s) may be required in the ~~ITB solicitation~~. Reference to literature submitted with a previous bid will not satisfy this provision. If necessary, the bidder shall also explain in detail the reason(s) why the proposed requirements may be satisfied with a substitute product. Bids lacking any written indication of intent to quote an alternate brand will be received and considered in complete compliance with the specifications as listed on the ~~bid form solicitation~~.

~~(n)~~ A bid constitutes a legal offer which becomes a contract upon acceptance by the Authority pursuant to OAC 317:10-1-10(k).

~~(o)~~ The ~~ITB bid~~ must be made out in the name of the bidder and must be fully and properly executed by an authorized person, ~~and~~ signed in ink, ~~and notarized~~ with full knowledge and acceptance of all its provisions.

~~(p)~~ In accepting a contract with the Authority, the bidder must agree to an audit clause which provides that books, records, documents, accounting procedures, practices or any other items of the bidder relevant to the contract are subject to examination by the Authority, and the State Auditor and Inspector.

~~(q)~~ Failure to comply with the terms and conditions will subject the bid to disqualification.

317:10-1-12. Protest of award

(a) Any bidder may protest the award of a bid. A protest may be based, but is not limited to, the following:

- (1) Error in the calculation of price;
- (2) The bid of the successful vendor did not meet the ~~bid solicitation~~ specifications;
- (3) The ~~bidding solicitation~~ procedure was done in violation of the Authority's rules; or
- (4) Authority personnel handling the ~~bidding solicitation~~ procedure acted in a willful or capricious manner.

(b) After the award is made, the protesting bidder shall submit written notice to the State Purchasing Director, Oklahoma Department of Central Services within ten (10) days of reasonable notice of contract award. The protest notice shall state supplier facts and reasons for protest.

(c) The State Purchasing Director shall review the protest and contract award documentation, responding to the protesting bidder as outlined in the Oklahoma Department of Central Services, Rules of the Central Purchasing Division, OAC 580:15-4-13.

317:10-1-15. Sole source or sole brand acquisitions

(a) The Authority need not seek competitive ~~bids solicitations~~ for goods or services, if the person with authority to make the acquisition affirms that:

- (1) The goods, equipment or services may only be obtained from a single or sole source; must be a sole brand; or,
- (2) A public exigency or emergency exists in which the urgency for the requirement will not permit a delay incident to competitive solicitation; or,
- (3) After solicitation of a number of sources, competition is deemed inadequate.

(b) The person wishing to make an acquisition through a sole source shall forward an affidavit to Contracts or Purchasing which gives all the reasons why the specifications to fill the need restricts the item or service to one person or business, or brand. The appropriate CPO shall confirm the information on the affidavit by consulting with the Central Purchasing Division, Office of State Finance, contacts in the business community, Internet searches and any other resources identified.

- (1) If the total acquisition price exceeds \$2,500 but does not exceed \$25,000:

~~(A) The appropriate CPO shall solicit quotations from at least three bidders to determine if the acquisition is a sole source acquisition.~~

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~~(B)~~ (A) If the CPO determines the acquisition is a sole source or sole brand, the affidavit shall be submitted to the CEO for signature of approval. In the prolonged absence of the CEO, the designee of the CEO may approve a sole source acquisition.

~~(C)~~ (B) Upon approval by the CEO or in the CEO's absence, the designee, the CPO completes the acquisition pursuant to the provisions of the Oklahoma Central Purchasing Act.

~~(D)~~ (C) The affidavit shall be maintained in a file within the Authority.

(2) If the total acquisition price exceeds \$25,000:

(A) The appropriate CPO shall submit the affidavit to the CEO or in the CEO's absence, to the designee for approval/signature.

(B) The affidavit and acquisition information shall be submitted to the State Purchasing Director, Oklahoma Department of Central Services for completion of the acquisition.

(C) Copies of the affidavit are maintained in a file within the Authority.

(c) Criteria which may be sufficient to justify a sole source or sole brand contract include, but are not limited to:

(1) Replacement or repair parts require the same brand.

(2) Compatibility of equipment or the continuity of services rendered from the same vendor is an essential factor for effective utilization of the product or service.

(3) The goods, service or equipment is the only one of its kind that will fulfill the need of the agency.

(4) The product or service furnished by the vendor is very specialized or the vendor providing the service possesses great acquired expertise, and the vendor is the only one singularly and peculiarly qualified to provide such product or service.

317:10-1-16. Delegation of authority

The authority to procure needed products and services for the Authority has been delegated to the Authority from the Oklahoma Department of Central Services, Central Purchasing Division. The Authority Board delegates procurement authority to the CEO and other Authority officers and personnel according to the dollar limits and types of products stated in (1), (2) and (3) of this Section. Within this authority, the CEO may delegate in writing to other specific individuals the responsibility for the performance of the procurement duties.

(1) **Supply and non-professional services acquisitions.** Each division director or supervisor may initiate any supply or non-professional services acquisition which is within his or her authorized division budget and approved by the CEO, associate director or designee. Any single acquisition of this kind over \$5,000 up to \$500,000 must be approved by the CEO or a designated associate director. Any single acquisition of this kind over \$500,000 must be approved by the Authority Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds \$500,000 for a supply or non-professional services contract must be prior approved by the OHCA Board. Any

amendment to a contract that would result in a 10 percent or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval.

(2) **Professional service contracts.** Acquisitions of professional services must be approved by the CEO or designee. All professional service contracts over \$125,000 must be approved by the Authority Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds \$125,000 for a professional service contract must be prior approved by the OHCA Board. Any amendment to a contract that would result in a 25 percent or greater increase or a \$250,000 or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval. Board approval is not required if the increase in total contract acquisition cost results from the exercise of a price increase methodology, option for additional work, or option to renew that was contained in the previously approved contract.

(3) **Interagency/intergovernmental agreements.** All agreements with another state agency or public agency must be approved by the CEO or designee, but are exempt from the Authority Board approval.

317:10-1-17. Acquisitions of \$2,500 or less

(a) Any acquisition for an amount of \$2,500 or less shall be exempt from the competitive ~~bidding~~ solicitation procedures. The items may be acquired by ~~an authority~~ a purchase order or purchase card order issued directly to the vendor and pursuant to the provisions of the Oklahoma Department of Central Services, Rules of the Central Purchasing Division, OAC ~~580:15-6-8-580:15-6-6~~.

(b) Contracts or Purchasing will monitor ~~authority~~ these orders to see if the combined usage from the various divisions for the same items exceeds the ~~dollar~~ \$2,500 amount for ~~authority~~ orders allowed. Should this occur, the division will be notified that competitive ~~bid~~ solicitation specifications must be prepared and that the acquisition will be processed in accordance with agency policy based upon the overall dollar amount of the acquisition.

(c) The Authority may not make split purchases for the purpose of evading the dollar threshold for competitive ~~bids~~ solicitations.

~~(d) The Authority may issue change orders to increase a purchase order for an acquisition not to exceed ten percent of the original purchase order total price.~~

317:10-1-18. Acquisitions in excess of \$2,500 and not exceeding \$10,000

(a) If the acquisition is for an amount exceeding \$2,500, but is not more than \$10,000, the appropriate CPO shall determine if the goods or services are available from a mandatory statewide contract, State Use Committee procurement schedule, scheduled acquisition, non-encumbered contract, ~~Oklahoma State Industries~~, another governmental agency

or from non-mandatory statewide contracts. If the goods or services are available through one of these methods, the agency will acquire the goods or services in this manner.

(b) If the acquisition is not available utilizing one of the methods stated in (a) of this Section, the agency shall acquire the goods or services by an open market acquisition.

(1) The CPO may select suppliers from the registered supplier list maintained by the Central Purchasing Division, Oklahoma Department of Central Services, suppliers that can meet the agency's delivery date or suppliers in the vicinity. Suppliers will not be chosen that have been suspended or debarred from the registered supplier list.

(2) The CPO shall secure price quotations and delivery dates from suppliers. Price quotations may be in writing or documented by the CPO.

(3) If the Authority and the supplier execute a contract for the acquisition, the supplier shall ~~attach~~ submit a notarized, sworn statement of non collusion pursuant to 74 O.S., Section 85.23.

(4) The Authority shall pay the supplier following receipt, inspection and acceptance of the acquisition.

(5) The Authority shall retain documents and records of each acquisition for three years following acquisition date.

(6) All records and documentation shall be made available to the State Auditor and Inspector or the State Purchasing Director, Oklahoma Department of Central Services, upon request. Further, all contracting and purchasing records required to be open under the Open Records Act shall be available.

(c) The Authority may not make split purchases for the purpose of evading the dollar threshold for competitive ~~bids~~ solicitations.

(d) The Authority may issue change orders to increase a purchase order for an acquisition not to exceed ten percent of the original purchase order total price. ~~The Authority shall notify the Department of Central Services, Purchasing Director, if a change order increases an acquisition purchase price above \$25,000.~~

317:10-1-18.1. Acquisitions in excess of \$10,000 and not exceeding \$25,000

(a) The CPO shall determine if the acquisition is available from a mandatory statewide contract, State Use Committee procurement schedule, scheduled acquisition, non-encumbered contract, ~~Oklahoma State Industries~~, another governmental agency or from a non-mandatory statewide contract. If the acquisition is available through one of these methods, the agency will acquire the goods or services in this manner.

(b) If the acquisition is not available utilizing one of the above methods, the agency shall acquire the goods or services by an open market acquisition.

(1) The CPO shall select a minimum of three ~~(3)~~ suppliers for ~~bid solicitation or request for quotation~~. The CPO may select suppliers from the registered supplier list maintained by the Central Purchasing Division, Oklahoma Department of Central Services, suppliers that can meet the agency's delivery date or suppliers in the vicinity.

Suppliers will not be chosen that have been suspended or debarred from the registered supplier list.

(2) The CPO shall secure price quotations and delivery dates from suppliers. Price quotations may be in writing or documented by the Certified Procurement Officer.

~~(3)~~ If a vendor submits a bid, the vendor shall submit an original notarized non collusion affidavit pursuant to 74 O.S., Section 85.22.

~~(34)~~ If the Authority and the supplier execute a contract for the acquisition, the supplier shall ~~attach~~ submit a notarized, sworn statement of non collusion pursuant to 74 O.S., Section 85.23.

~~(45)~~ The Authority shall pay the supplier following receipt, inspection and acceptance of the acquisition.

~~(56)~~ The Authority shall retain documents and records of each acquisition for three years following acquisition date.

~~(67)~~ All records and documentation shall be made available to the State Auditor and Inspector or the State Purchasing Director, Oklahoma Department of Central Services, upon request. Further, all purchasing records required to be open under the Open Records Act shall be available.

(c) The Authority may not make split purchases for the purpose of evading the dollar threshold for competitive ~~bids~~ solicitations.

(d) The Authority may issue change orders to increase a purchase order for an acquisition not to exceed ten percent of the original purchase order total price. The Authority shall notify the Department of Central Services, State Purchasing Director, if a change order increases an acquisition purchase price above \$25,000.

317:10-1-18.2. Acquisitions in excess of \$25,000

(a) The CPO shall determine if the acquisition is available from a mandatory statewide contract, State Use Committee procurement schedule, scheduled acquisition, non-encumbered contract, ~~Oklahoma State Industries~~, another governmental agency or from a non-mandatory statewide contract. If the acquisition is available through one of these methods, the agency will acquire the goods or services in this manner subject to the provisions of OAC 317:10-1-16.

(b) If the acquisition is not available utilizing one of the above methods, the agency shall submit a request for the acquisition to the State Purchasing Director, Oklahoma State Department of Central Services.

317:10-1-19. Professional service contracts

(a) The Contracts Unit (Contracts) is the official repository for all original professional service agreements/contracts except as otherwise authorized by the CEO. Divisions must forward to Contracts all original agreements/contracts in their files. A standard format for all agreements will be on file and any changes will be coordinated with Contracts. Any correspondence affecting the contract must also be forwarded to Contracts. Contracts staff will assist agency personnel in

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obtaining copies of documents requested from the files. Contracts' central file will contain:

- (1) Official copy of the agreement/contract,
 - (2) Amendments,
 - (3) Compliance audits or reviews,
 - (4) Historical vendor performance,
 - (5) The requisition, and
 - (6) Other related documents including purchase orders.
- (b) The Authority may not enter into a professional service contract with any person who has been employed by the Authority within one year after the termination date of the individual's employment, unless specifically permitted by statute. This shall not apply to contracts with qualified interpreters for the deaf.
- (c) All professional services contracts shall contain an audit clause which provides that books, records, documents, accounting procedures, practices and any other item of the services provider relevant to the contract are subject to examination by OHCA or the State Auditor and Inspector.
- (d) The Authority shall monitor and ~~audit~~ review compliance all professional services contracts periodically, but not less than twice during the contract period.
- (e) A performance evaluation is required of the service provided under a professional service contract. Such evaluations shall assess the performance of the vendor during the contractual period. Evaluations shall be completed by the division responsible for initiating the contract no less than 90 days after the end of the contract. A copy of each evaluation is forwarded to Contracts for filing in the contract file.
- (f) If the final product of a contract is a report, written proposal or study, the vendor shall comply with the following:
- (1) the vendor shall provide a sworn statement certifying that said vendor has not previously entered into a contract with the Authority or any other state agency which would result in a substantial duplication of the previous end report. A sworn statement shall not be required of a vendor who is renewing a contract; and
 - (2) the vendor must deliver two copies of the report to Contracts. Contracts will file one copy with the State Librarian and Archivist.
- (g) Contract terms and price must be definite and fixed. Contracts for professional services shall provide for payments to vendors at a uniform rate for the duration of the contract if the services being provided are similar and consistent. If the professional services are not similar and consistent for the duration of the contract, the Authority shall comply with the provisions of 74 O.S., 1998, Section 85.41(G).
- (h) The following professional services are exempt from competitive bidding pursuant to 74 O.S., Section 85.7(2), and 18 O.S., Section 803:
- (1) Physician, Surgeon or doctor of medicine;
 - (2) Osteopathic Physician or Surgeon;
 - (3) Chiropractor;
 - (4) Chiropodist-podiatrist;
 - (5) Optometrist;
 - (6) Veterinarian;
 - (7) Architect;
 - (8) Attorney;

- (9) Dentist;
- (10) Public Accountant;
- (11) Psychologist;
- (12) Physical Therapist;
- (13) Registered Nurse;
- (14) Professional Engineer;
- (15) Land Surveyor;
- (16) Pharmacist;
- (17) Occupational Therapist;
- (18) Speech Pathologist;
- (19) Audiologist; and
- (20) Licensed Perfusionist.

(i) The Authority shall require proof of professional certification or license of all vendors providing professional services described in (h) of this Section.

(j) All professional service contracts other than those specified in (h) of this Section must be competitively bid pursuant to this Chapter unless criteria exist sufficient to justify a sole source contract, or unless the contract does not exceed the \$25,000 threshold required for competitive bidding, or as otherwise provided by state law.

(k) The requirement for competitive bidding may not be avoided by entering into a contract with an individual licensed in one of the professional categories identified in (h) of this Section, to perform non-germane services. For example, a lawyer may not be given a contract to serve as an investment counselor without competitive bidding.

(l) Bids for professional services contracts shall be evaluated by the appropriate division and/or evaluation team, and reviewed by the Contracts Administrator or designee prior to submittal to the State Purchasing Director. Both cost and technical expertise shall be considered in determining the lowest and best or best value bid.

(m) The travel expenses to be incurred by the vendor pursuant to the contract for services shall be included in the total amount of the contract award, unless the Authority decides to reimburse the vendor under state statutes for such expenses, and informs vendors of such reimbursement in the ITB or request for proposal. The vendor shall be responsible for all travel arrangements and provide supporting documentation when submitting claims for reimbursement.

317:10-1-20. Interagency/Intergovernmental agreements

(a) OHCA may contract with another state agency pursuant to 74 O.S., Section 581.

(b) OHCA may contract with a political subdivision or agency of the United States pursuant to 74 O.S., Sections 1001 through 1008.

(c) OHCA shall not attempt to make or make an acquisition through another state agency or public agency for the purpose of evading competitive ~~bid~~ solicitation provisions of the Oklahoma Central Purchasing Act or rules of the Central Purchasing Division.

[OAR Docket #07-693; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 25. SOONERCARE CHOICE**

[OAR Docket #07-701]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 7. SoonerCare Choice
Part 3. Enrollment Criteria
317:25-7-13 [AMENDED]
(Reference APA WF # 06-19)

AUTHORITY:

Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.1008

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April 4, 2007

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 7. SoonerCare Choice
Part 3. Enrollment Criteria
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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

SoonerCare Choice rules are revised to exclude individuals residing in an Institution for Mental Disease (IMD) from the SoonerCare Choice program. Currently, children residing in out-of-state behavioral health facilities, due to the inability of state facilities meeting their special needs, are included in the SoonerCare program. Federal regulations state that Federal Financial Participation is unavailable for individuals in an IMD (42 CFR 435.1008). Therefore, to comply with federal regulations, SoonerCare Choice rules are revised to exclude individuals residing in Institutions for Mental Disease.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTION 308.1(A), WITH AN EFFECTIVE DATE
OF MAY 11, 2007:**

SUBCHAPTER 7. SOONERCARE CHOICE

PART 3. ENROLLMENT CRITERIA

317:25-7-13. Enrollment ineligibility

Clients Members in certain categories are excluded from participation in the SoonerCare program. All other clients members are enrolled in the SoonerCare program and subject to the provisions of this Subchapter. Clients Members excluded from participation in SoonerCare include:

- (1) Individuals receiving services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver.
- (2) Individuals privately enrolled in an HMO.
- (3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services, or a greater or lesser distance/driving time as determined pursuant to OAC 317:25-7-10(a).
- (4) Children who are known to the OHCA to be in custody, as reported by the Oklahoma Department of Human Services.
- (5) Individuals who are eligible for Medicaid Sooner-Care solely due to presumptive eligibility.
- (6) Non-qualified or ineligible aliens.
- (7) Children in subsidized adoptions.
- (8) Individuals who are dually-eligible for Medicaid and Medicare.
- (9) Individuals who are in an Institution for Mental Disease (IMD).

[OAR Docket #07-701; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-700]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-40 [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 41. Family Support Services
317:30-5-410 through 317:30-5-412 [AMENDED]
Part 51. Habilitation Services
317:30-5-480 through 317:30-5-482 [AMENDED]
(Reference APA WF # 06-07 and 06-48A)

AUTHORITY:

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Part 51. Habilitation Services
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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Developmental Disability Services Division Habilitation Services rules are revised to add the need for a prescription for specific services in the Individual's Plan which lists the service recipient's need for support. Several years ago, a Centers for Medicare and Medicaid Services audit of DDSDD Medicaid services revealed that a required prescription for several therapies and services were often not found in the service recipient's Individual's Plan. Our requirements for a prescription for occupational therapy, physical therapy, speech/language services, and audiology services are found in the specific rules for those services but currently are not in the Habilitation Services rules. The Oklahoma Department of Human Services Developmental Disability Services Division has requested revisions to rules to add this requirement to the Habilitation Services rules. Revisions are needed to add the requirement for a prescription in the Individual's Plan for specific services.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and Community-Based Waiver Services Waivers for persons with mental retardation or certain persons with related conditions

The State of Oklahoma has a Medicaid waiver to provide home and community-based services to mentally retarded recipients who would otherwise require institutional care in an intermediate care facility for the mentally retarded. Area professional assessment teams are interdisciplinary teams which perform the initial client assessment to determine a diagnosis of mental retardation and eligibility for waiver services. They also develop the individual plan of care for each recipient. The services which are available include: Case management, habilitation services, specialized foster care, respite care and homemaker services. Following is a brief description of each service:

(1) **Case management services.** Case management is a system under which the responsibility for locating, coordinating and monitoring a group of services rests with a specific person.

(2) **Habilitation services.** Habilitation services are services which are needed to ensure optimal functioning of the recipient of home and community based services. Services include physical therapy, occupational therapy, nutritional services, psychiatric services, psychological services, speech therapy, audiological examination/treatment, habilitation training, employment support services, dental examination, personal supports, and adult day services.

(3) **Specialized foster care.** Specialized foster care is family like care and services provided to recipients by individuals and families living in their own homes.

(4) **Respite care.** Respite care is services designed to provide temporary or intermittent support to clients to relieve the family or primary care provider in planned absences or emergencies.

(5) **Homemaker services.** Homemaker services are services to assure client safety and well being when the regular caretaker is absent or unable to perform domestic activities such as meal preparation, shopping, household cleaning and personal hygiene and care services.

(a) **Introduction to HCBS Waivers.** The Medicaid Home and Community-Based Services (HCBS) Waiver programs are authorized in accordance with Section 1915(c) of the Social Security Act.

(1) Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSDD) operates HCBS Waiver programs for persons with mental retardation and certain persons with related conditions. Oklahoma Health Care Authority (OHCA), as the State's single Medicaid agency, retains and exercises administrative authority over all HCBS Waiver programs.

(2) Each waiver allows for the provision of specific Medicaid-compensable services that assist members to reside in the community and avoid institutionalization.

(3) Waiver services:

(A) complement and supplement services available to members through the Medicaid State Plan or other

federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) can only be provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution; and

(C) are not intended to replace other services and supports available to members.

(4) Any waiver service must be:

(A) appropriate to the member's needs; and

(B) included in the member's Individual Plan (IP).

(i) The IP:

(I) is developed annually by the member's Personal Support Team, per OAC 340:100-5-52; and

(II) contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized in accordance with OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDSD furnishes case management, targeted case management, and services to members as a Medicaid State Plan service under Section 1915(g)(1) of the Social Security Act in accordance with OAC 317:30-5-1010 through 317:30-5-1012.

(b) Eligible providers. All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with mental retardation or related conditions.

(c) Coverage. All services must be included in the member's IP. Arrangements for services must be made with the member's case manager.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 41. FAMILY SUPPORT SERVICES

317:30-5-410. Introduction to waiver services and eligible providers Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

~~(a) Introduction to waiver services. The Oklahoma Health Care Authority (OHCA) administers two home and community based waivers for services to individuals Home and Community-Based Services (HCBS) Waivers for persons with mental retardation or and certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). Both waivers are enacted under Section 1915(e) of the Social Security Act. Each waiver allows payment for family support services provided to eligible individuals that are not covered through Oklahoma's Medicaid program as defined in the waiver approved by the Centers for Medicare and Medicaid Services. Waiver services, when utilized with~~

~~services normally covered by Medicaid, provide for health and developmental needs of individuals who otherwise would not be able to live in a home or community setting. The first waiver, implemented in 1988, provides home and community based services for mentally retarded individuals who otherwise require the level of care in an Intermediate Care Facility for the Mentally Retarded. The second waiver, implemented in 1991, provides home and community based services to persons with mental retardation or related conditions who are inappropriately placed in nursing facilities. The specific services provided are the same in each waiver and may only be provided to Medicaid eligible individuals outside of a nursing facility. Any waiver service should be appropriate to the client's needs and must be written on the client's Individual Habilitation Plan (IHP). The IHP is developed annually by an interdisciplinary team (IDT). The IHP contains detailed descriptions of services provided, documentation of frequency of services and types of providers to provide services.~~

~~(b) Eligible providers. All Family Support Services providers must have entered into contractual agreements (MA S 342) with the Oklahoma Health Care Authority to provide Home and Community-Based Waiver Services for the Mentally Retarded.~~

317:30-5-411. Coverage

~~All Family Support Services family support services will be included in the member's Individual Habilitation Plan (IHP IP) and reflected in the approved plan of care. Arrangements for care under this program must be made with the individual client's member's case manager.~~

317:30-5-412. Description of services

~~Family Support Services support services include the following: services identified in paragraphs (1) through (6).~~

~~(1) Transportation services. Transportation services are provided in accordance with OAC 317:40-5-103.~~

~~(2) Adaptive equipment services. Adaptive equipment, (assistive technology) also known as environmental accessibility adaptations, services are provided in accordance with OAC 317:40-5-100.~~

~~(3) Architectural modification. Architectural modification services are provided in accordance with OAC 317:40-5-101.~~

~~(4) Family training.~~

~~(A) Minimum qualifications. Training providers must hold current licensure as a clinical social worker, psychologist, professional counselor, psychiatrist, or registered nurse, nutritionist/dietitian, physical therapist, occupational therapist or speech therapist. Training may also be provided by other local or state agencies whose programs trainers have been approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) Director-director of Training Human Resource Development.~~

~~(B) Description of services. Family Training Services training services include instruction in skills and~~

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knowledge pertaining to the support and assistance of ~~persons with developmental disabilities provided to individuals and natural, adoptive or foster families of eligible individuals age six and older~~ members. Services are:

(i) ~~intended to allow families to become more proficient in meeting the needs of eligible individuals.~~ members who are eligible;

(ii) ~~Services are provided in any community setting; in which the individual/family resides and/or the provider conducts business and may be~~

(iii) ~~provided in either group (2-15 consisting of two to 15 persons), or individual formats;~~ and

(iv) ~~for families of members served through DDS Home and Community-Based Services (HCBS) Waivers. For the purpose of this service, family is defined as any person who lives with or provides care to a member served on the waiver.~~

(C) **Coverage limitations.** ~~Payment rates and coverage~~ Coverage limitations for family training are as follows:

(i) Description: Individual Family Training family training; Limitation: \$5,500 ~~each 12 months.~~ per Plan of Care year; and

(ii) Description: Group Family Training family training; Limitation: \$5,500 ~~each 12 months~~ per Plan of Care year.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(i) service date;

(ii) start and stop time for each session;

(iii) signature of the trainer;

(iv) credentials of the trainer;

(v) specific issues addressed. Issues must be identified in the member's Individual Plan (IP);

(vi) methods used to address issues;

(vii) progress made toward outcomes;

(viii) member's response to the session or intervention; and

(ix) any new issue identified during the session.

(5) Family counseling.

(A) **Minimum qualifications.** Counseling providers must hold current licensure as a clinical social worker, psychologist, or professional counselor.

(B) **Description of services.** ~~Family Counseling Services include counseling in emotional and social issues provided to eligible individuals age six and older and their natural, adoptive or foster families. Services are intended to maximize individual's/family's emotional/social adjustment and well-being. Services are rendered in any setting in which the individual/family resides or the provider's office and may be provided in either group (six person maximum) or individual formats. Family counseling, offered specifically to members and their natural,~~

~~adoptive, or foster family members, helps to develop and maintain healthy, stable relationships among all family members.~~

(i) Emphasis is placed on the acquisition of coping skills by building upon family strengths.

(ii) Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home.

(iii) All family counseling needs are documented in the member's IP.

(C) **Coverage limitations.** ~~Payment rates and coverage~~ Coverage limitations for family counseling are as follows:

(i) Description: Individual Family Counseling family counseling; Unit: 15 minutes; Limitation: 400 units ~~each 12 months.~~ per Plan of Care year; and

(ii) Description: Group Family Counseling family counseling; Unit: 30 minutes; Limitation: 225 units ~~each 12 months~~ per Plan of Care year.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(i) service date;

(ii) start and stop time for each session;

(iii) signature of the therapist;

(iv) credentials of the therapist;

(v) specific issues addressed. Issues must be identified in the member's IP;

(vi) methods used to address issues;

(vii) progress made toward outcomes;

(viii) member's response to the session or intervention; and

(ix) any new issue identified during the session.

(6) Specialized medical supplies.

(A) **Minimum qualifications.** ~~Specialized medical equipment providers must meet all applicable state and local requirements for licensure and/or certification. Providers must:~~

(i) be registered to do business in Oklahoma or in the state in which they are domiciled;

(ii) have a Medicaid contract with Oklahoma Health Care Authority to provide unrestricted durable medical equipment to members receiving HCBS; and

(iii) enter into this agreement:

(I) giving assurance of ability to provide products and services; and

(II) agree to the audit and inspection of all records concerning goods and services provided.

(B) **Description of services.** ~~Specialized medical supplies include supplies specified in the plan of care, which member's IP that enable individuals the member to increase their abilities to perform his or her ability in the performance of activities of daily living. This service~~ Specialized medical supplies also

includes ~~include~~ the purchase of ancillary supplies not available under Oklahoma's Title XIX ~~the Medicaid State Plan,~~

~~(i) and excludes~~ Supplies furnished through an HCBS waiver are in addition to any supplies furnished under the Medicaid State Plan and exclude those items which that are not of direct medical and remedial benefit to the individual member.

~~(ii) All items shall~~ supplies must meet applicable standards of manufacture, design, and installation.

~~(iii) Supplies include, but are not limited to:~~

~~(i) prescriptions in excess of Medicaid limitations;~~

~~(ii I) adult briefs;~~

~~(iii II) nutritional supplements;~~

~~(iv III) supplies needed for tracheotomy/respirator/ventilator care; and~~

(IV) supplies needed for health conditions;

(v V) supplies for decubitus care; and

(VI) supplies for catheterization.

(C) Coverage limitations. Specialized medical services supplies are billed using the appropriate HCPC Code procedure code. Individual limits are specified in each ~~recipient's IHP~~ member's IP. All services require prior authorization are authorized in accordance with OAC 317:40-5-104.

PART 51. HABILITATION SERVICES

317:30-5-480. ~~Introduction to waiver services and eligible providers~~ Home and Community-Based Services for persons with mental retardation or certain persons with related conditions

~~(a) Introduction to waiver services.~~ The Oklahoma Health Care Authority (OHCA) ~~administers two home and community based waivers for services to individuals~~ persons with mental retardation or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). Both waivers are enacted under Section 1915(e) of the Social Security Act. Each waiver allows payment for Medicaid compensable services provided to persons who are:

(1) medically and financially eligible; and

(2) individuals that are not covered through Oklahoma's Medicaid the OHCA SoonerCare program. Waiver services, when utilized with services normally covered by Medicaid, provide for health and development needs of individuals who otherwise would not be able to live in a home or community setting. The first waiver, implemented in 1988, provides home and community based services for mentally retarded individuals who otherwise require the level of care in an Intermediate Care Facility for the Mentally Retarded. The second waiver, implemented in 1991, provides home and community

~~based services to persons with mental retardation or related conditions who are inappropriately placed in nursing facilities. The specific services provided are the same in each waiver and may only be provided to Medicaid eligible individuals outside of a nursing facility. Any waiver service should be appropriate to the client's needs and must be written on the client's Individual Habilitation Plan (IHP). The IHP is developed annually by an interdisciplinary team (IDT). The IHP contains detailed descriptions of services provided, documentation of frequency of services and types of providers to provide services.~~

~~(b) Eligible providers.~~ All Habilitation Services providers must have entered into contractual agreements (MA S 342) with the Oklahoma Health Care Authority to supply Home and Community Based Waiver Services for the Mentally Retarded. ~~Payment for occupational therapy assistant and physical therapy assistant services will be made only to the employing entity.~~

317:30-5-481. Coverage

All ~~Habilitation Services~~ habilitation services will be ~~authorized~~ included in the ~~member's Individual Habilitation Plan (IHP IP) and reflected in the approved plan of care.~~ Arrangements for care under this program must be made with the ~~individual client's Case Manager~~ member's case manager.

317:30-5-482. Description of services

Habilitation ~~Services~~ services include the services ~~described~~ identified in this Section (1) through (13).

(1) Dental services.

(A) Minimum qualifications. Providers of dental services must have a non-restrictive licensure to practice dentistry in the ~~State of Oklahoma~~ by the Board of Governors of Registered Dentists of Oklahoma.

(B) Description of services. Dental ~~service~~ includes services include:

(i) oral examination; ;

(ii) ~~two~~ bite-wing x-rays; ;

(iii) prophylaxis; ;

(iv) topical fluoride treatment; ;

(v) development of a treatment plan; of care on the specified form and

(vi) routine training of client member or primary ~~care-giver~~ caregiver regarding oral hygiene; and

(vii) any other service recommended by a dentist.

(C) Coverage limitations. ~~Services are limited to 5 each 12 months.~~ Coverage of dental services is specified in the member's Individual Plan (IP), in accordance with applicable Home and Community-Based Services (HCBS) Waiver limits.

(2) Nutritional Nutrition services.

(A) Minimum qualifications. Providers of nutrition services must be licensed by the Oklahoma State

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Board of Medical Examiners and registered as a dietitian with the Commission of Dietetic Registration.

(B) **Description of services.** ~~Nutritional~~ Nutrition services include evaluation and consultation in diet to ~~eligible individuals, members or their guardian, six years of age and older caregivers.~~

(i) Services are:

(I) intended to maximize the ~~individual's~~ member's nutritional health; ~~and~~

(II) ~~Services are~~ provided in any community setting as specified in the ~~individual's IHP~~ member's IP.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 192 units ~~each 12 months~~ per Plan of Care year.

(3) Occupational therapy services.

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

(B) **Description of services.** ~~Skilled occupational~~ Occupational therapy services include evaluation, treatment, ~~and consultation, program development/management in leisure management, and equipment monitoring daily living skills, sensory motor, perceptual motor, and mealtime assistance.~~ ~~Skilled occupational~~ Occupational therapy services may ~~also~~ include the use of occupational therapy assistants, within the limits of their practice.

(i) Services are:

(I) intended to help the ~~consumer~~ member achieve greater independence to reside and participate in the community; ~~and~~

(II) ~~Services are~~ rendered in any community setting as specified in the ~~individual's habilitation plan~~ member's IP. The IP must include a physician's prescription.

(ii) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants, and advanced practice nurses in accordance with the rules and regulations covering the OHCA's medical care program.

(iii) The provision of services ~~include~~ includes written report or record documentation in the ~~individual's~~ member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapy assistant within their employment.

(i) Services provided by occupational therapy assistants must be identified on the claim form by

the use of the occupational therapy assistant's individual provider number in the servicing provider field.

(ii) Payment is made in 15-minute units, with a limit of 480 units ~~each 12 months~~ per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) Physical therapy services.

(A) **Minimum qualifications.** Physical therapists and physical therapy assistants must be licensed with the Oklahoma State Board of Medical Licensure and Supervision. The physical therapy assistant must be employed by the physical therapist.

(B) **Description of services.** ~~Skilled physical~~ Physical therapy services include evaluation, treatment, ~~and consultation, program development/management and equipment monitoring in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being.~~ ~~Skilled physical~~ Physical therapy services may ~~also~~ include the use of physical therapy assistants, within the limits of their practice.

(i) Services are intended to help the ~~consumer~~ member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the ~~individual's habilitation plan~~ member's IP. The IP must include a physician's prescription.

(ii) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants, and advanced practice nurses in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services ~~include~~ includes written report or record documentation in the ~~individual's~~ member's record, as required.

(C) Coverage limitations.

(i) Payment is made for:

(I) compensable services to the individual physical therapist for direct services; ~~or~~

(II) ~~for~~ services provided by a qualified physical therapy assistant within ~~their~~ his or her employment.

(ii) Services provided by physical therapy assistants must be identified on the claim form by the use of the physical therapy assistant's individual provider number in the servicing provider field.

(iii) Payment is:

(I) made in 15-minute units with a limit of 480 units ~~each 12 months~~ per Plan of Care year; ~~and~~ -

(II) ~~Payment is~~ not allowed solely for written reports or record documentation.

(5) Psychological services.

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires non-restrictive licensure as a psychologist by the Oklahoma

Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment ~~provided to eligible individuals six years of age and older.~~ Service is provided in any community setting as specified in the ~~individual's habilitation plan~~ member's IP.

(i) Services are:

(I) intended to maximize ~~an individual's~~ a member's psychological and behavioral well-being; ~~;~~ and

(II) ~~Services are provided in both individual and group (6 six person maximum), format formats.~~

(ii) A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are ~~as follows:~~

(I) Description: Psychotherapy ~~Services services~~ and ~~Behavior Treatment Services behavior treatment services~~ (~~Individual individual~~): Unit: 15 minutes; ~~;~~ and

(II) Description: ~~Cognitive/Behavioral Treatment Cognitive/behavioral treatment~~ (~~Group group~~): Unit: 15 minutes.

(ii) Psychological services will be authorized for a period not to exceed six months.

(I) Initial authorization is through the case manager, with review and approval by the ~~case manager management~~ supervisor.

(II) Initial authorization will not exceed 192 units (48 hours of service).

(III) Monthly progress notes will include a statement of hours and type of service provided, and an empirical measure of ~~client member~~ status as it relates to each objective in the ~~treatment plan member's IP.~~

(IV) If progress notes are not submitted to the case manager for each month of service provision, authorization for payment will be withdrawn until such time as progress notes are completed.

(iii) Treatment extensions may be authorized by the ~~Area Manager area manager~~ based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, ~~and/or~~ treatment effectiveness, ~~or both~~, is submitted by the ~~service~~ provider to the case manager and will include, as a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a ~~treatment plan~~ Protective Intervention Plan (PIP) to accommodate

recommendations of a required committee review or ~~a~~ an Oklahoma Department of Human Services (OKDHS) audit, the ~~Provider provider~~ may bill for only one revision. The time for preparing the revision will be clearly documented and will not exceed four hours.

(III) Treatment extensions will be for no more than 24 hours (96 units) of service per request.

(iv) ~~Provider shall~~ The provider must develop, implement, evaluate, and revise the ~~treatment plan PIP~~ corresponding to the relevant goals and objectives, ~~for which the provider is responsible,~~ identified in the ~~IHP member's IP.~~

(v) No more than 12 hours (48 units) may be billed for the preparation of a ~~treatment plan PIP.~~ Any clinical document ~~shall~~ must be prepared within 45 days of the request; further payments will be suspended until the requested document is provided.

(~~v~~vi) Psychological ~~Technicians shall~~ technicians must provide no more than 140 billable hours (560 units) of service per month to ~~consumers members.~~

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric Services services.**

(A) **Minimum qualifications.** Qualification as a provider of psychiatric services requires a non-restrictive license to practice medicine in the State of Oklahoma. Certification by the Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, and medication and prescription ~~and~~ management and consultation provided to members who are eligible individuals six years of age and older. Services are provided in any community setting as specified in the ~~individual's habilitation plan~~ member's IP.

(i) Services are intended to contribute to the ~~individual's~~ member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, ~~and is limited to with a limit of 200 units each 12 months per Plan of Care year.~~

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a provider of speech/language services requires non-restrictive licensure as a speech/language pathologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor/feeding activities provided to members who are eligible individuals

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~~six years of age and older. Services are intended to maximize the individual's member's community living skills and may be provided in any community setting as specified in the individual's habilitation plan member's IP. The IP must include a physician's prescription.~~

~~(i) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants, and advanced practice nurses in accordance with rules and regulations covering the OHCA's SoonerCare program.~~

~~(ii) A minimum of 15 minutes for encounter and record documentation is required.~~

~~(C) Coverage limitations. A unit is 15 minutes, and is limited to with a limit of 288 units each 12 months per Plan of Care year.~~

~~(8) Habilitation Training Specialist Services training specialist (HTS) services.~~

~~(A) Minimum qualifications. Providers must complete the Oklahoma Department of Human Services/Developmental OKDHS Developmental Disabilities Services Division (OKDHS/DDSD DDSD) sanctioned training curriculum in accordance with the schedule authorized by DDSD. Residential habilitation providers:~~

~~(i) are at least 18 years of age;~~

~~(ii) are specifically trained to meet the unique needs of members;~~

~~(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2), unless a waiver is granted per 56 O.S. § 1025.2; and~~

~~(iv) receive supervision and oversight from a contracted agency staff with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.~~

~~(B) Description of services. HTS services include participation in evaluation, assistance and training in services to support the member's self-care, daily living, and adaptive and prevocational leisure skills provided needed to eligible individuals six years of age and older reside successfully in the community. Services are provided in any community-based setting as specified in the individual's habilitation plan settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.~~

~~(i) Payment will not be made for:~~

~~(I) routine care and supervision that is normally provided by family; or~~

~~(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.~~

~~(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member.~~

~~(iii) Payment does not include room and board or maintenance, upkeep, and improvement of the member's or family's residence.~~

~~(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.~~

~~(v) Case management supervisor review and approval is required.~~

~~(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services but is are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an oversight agency approved by the Authority OHCA. For pre-authorized HTS services, the service:~~

~~(I) provider will receive oversight from DDSD area staff; and~~

~~(II) This service must be pre-approved by the DDSD administrator-director or designee.~~

~~(C) Coverage limitations. Coverage limitations for HTS services are as follows: authorized as specified in OAC 317:40-5-110, 317:40-5-111, and 317:40-7-13, and OAC 340:100-3-33.1.~~

~~(i) Habilitation Training Specialist Services: Payment Limitation: As specified in IHP. A unit is one hour 15 minutes.~~

~~(ii) Habilitation Training Specialist Services (Pre-Vocational): Limitation: As specified in IHP. A Unit is one hour.~~

~~(iii) Habilitation Training Specialist Services (Preauthorized): Limitation: As specified in IHP. A Unit is one hour.~~

~~(D) ii) Habilitation training provisions. Individual HTS services providers will be limited to a maximum of 40 hours per week regardless of the number of clients members served.~~

~~(iii) More than one Habilitation Training Specialist HTS may provide care to a client member on the same day.~~

~~(iv) However, payment Payment cannot be made for services provided by two or more Habilitation Training Specialists HTSs to the same client member during the same hours of a day.~~

~~(v) A HTS may receive reimbursement for providing services to only one member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.~~

~~(9) Audiology services.~~

~~(A) Minimum qualifications. Audiologists must have licensure as an audiologist by the State Board of Examiners for Speech Pathology and Audiology.~~

(B) **Description of services.** ~~Audiology services include individual evaluation, treatment, and consultation in hearing provided to members who are eligible individuals six years of age and older. Services are intended to maximize the individual's member's auditory receptive abilities. Services are provided in any community setting as specified in the individual's habilitation plan. The member's IP must include a physician's prescription.~~

~~(i) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants, and advanced practice nurses in accordance with rules and regulations covering the OHCA's SoonerCare program.~~

~~(ii) A minimum of 15 minutes for encounter and record documentation is required.~~

~~(C) Coverage limitations. A unit is 15 minutes and is limited to 288 units each 12 months. Audiology services are provided in accordance with the service recipient's IP.~~

~~(10) **Employment Training Services.**~~

~~(A) **Minimum qualifications.** Employment specialists must have completed the OKDHS/DDSD sanctioned training curriculum.~~

~~(B) **Description of services.** Employment Training Services include evaluation, training, supportive assistance and remunerative employment in meaningful vocational activity provided in accordance with OAC 317:40-7 to eligible individuals 16 years of age or older who have previously resided in an ICF/MR and are unable to receive services funded by Rehabilitation Services Division. Services are intended to allow individuals to engage in meaningful work. The services are offered in generic employment settings in which individuals without disabilities are also employed.~~

~~(C) **Coverage limitations.** A unit is one hour. The number of hours which may be used per Plan of Care year is the number of hours per week the consumer works times 6.5.~~

~~(11) **Center-Based Prevocational Services services.**~~

~~(A) **Minimum qualifications.** Paraprofessional staff must Prevocational services providers:~~

- ~~(i) are at least 18 years of age;~~
- ~~(ii) complete the OKDHS/DDSD OKDHS DDSD designated sanctioned training curriculum;~~
- ~~(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and~~
- ~~(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.~~

~~(B) **Description of services.** Center based services are provided in accordance with OAC 317:40-7-6 and include activities designed to teach concepts such as task completion, problem solving, safety, promptness and skills that prepare an individual for paid or unpaid employment. These are not job task oriented but are, instead, aimed at generalized result. These services are provided in segregated settings, i.e., sheltered workshops. Eligible individuals must have previously resided in an ICF/MR, be unable to receive this service from the Department of Rehabilitation Services or the public schools and if compensated, are compensated at less than 50 per cent of minimum wage. Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.~~

~~(i) Prevocational services are provided to members who are not expected to:~~

- ~~(I) join the general work force; or~~
- ~~(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.~~

~~(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but a underlying habilitative goals, such as attention span and motor skills.~~

~~(iii) All prevocational services will be reflected in the member's IP as habilitative, rather than explicit employment objectives.~~

~~(iv) Documentation will be maintained in the record of each member receiving this service noting that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.~~

~~(v) **Services include:**~~

- ~~(I) center-based prevocational services as specified in OAC 317:40-7-6;~~
- ~~(II) community-based prevocational services as specified in OAC 317:40-7-5;~~
- ~~(III) enhanced community-based prevocational services as specified in OAC 317:40-7-12; and~~
- ~~(IV) supplemental supports as specified in OAC 317:40-7-13.~~

~~(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and the payment is based upon the number of hours the recipient member participates in the service. The number of units a recipient may receive is~~

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limited to 15 hours per week unless an exception is approved in accordance with OAC 317:40-7-21. All prevocational services and supported employment services combined may not exceed \$25,000 per Plan of Care year.

(12) Community-Based Prevocational Services.

(A) Minimum qualifications. Community-based skill training specialists must comply with the OKDHS/DDSD training requirements.

(B) Description of Services. Community-based services are provided in accordance with OAC 317:40-7-5 in sites typically used by others in the community which promote individual independence and inclusion within the community. Examples of such activities include unpaid work experience (volunteering), job sampling, or training through trade schools, libraries and other community groups. Eligible individuals must have previously resided in an ICF or ICF/MR and be unable to receive these services from the Department of Rehabilitation Services or the public schools.

(C) Coverage limitations. A unit is one hour and the payment is based upon the number of hours the recipient participates in the service. For individuals determined to require enhanced supports, an enhanced rate may be approved by the interdisciplinary team and included in the plan of care in accordance with OAC 317:40-7-12. A unit is one hour and the payment is based upon the number of hours the recipient participates in the service. The number of reimbursable units is limited to 30 per week, per recipient.

(13) Job Coaching Services.

(A) Minimum qualifications. Job coaches must have a high school diploma or have passed the general educational development test (G.E.D.) and be certified as job coaches through the OKDHS/DDSD designated training.

(B) Description of services. Job coaching includes primarily on-site training and all other activities initiated by certified agency staff promoting an individual's capacity to secure and maintain an integrated job of choice paying at or above minimum wage, in accordance with OAC 317:40-7-7. Enclaves consisting of two to eight employees, needing continuous support, situated in close proximity at an integrated work site are included in job coaching services even through these programs often reimbursed at less than minimum wage. Billing for job coaching services is authorized when on-site supports by a certified job coach are provided more than 20% of the individual's compensable work time. Eligible individuals must be 16 years of age or older, have previously resided in an ICF or ICF/MR and are unable to receive these services through the Department of Rehabilitation Services or through the state or local education agency.

(C) Coverage limitations. A unit is one hour and payment is for each hour of work performed by the

recipient. For individuals determined to require enhanced supports, an enhanced rate for each hour of work performed by the recipient may be approved by the interdisciplinary team and included in the plan of care. Reimbursable units are limited to 30 per week per recipient.

(14) Stabilization/Extended service.

(A) Minimum qualifications. Job coaches must have a high school diploma or have passed the general educational development test (G.E.D.) and be certified as job coaches through the DHS/DDSD designated training.

(B) Description of services. Stabilization and extended services are ongoing support services and other appropriate services needed to support and maintain an individual with severe disabilities in an integrated competitive employment site in accordance with OAC 317:40-7-11. These services are provided when the job coach intervention time required at the job site is 20% or less of the individual's total work hours. Extended services must include, at a minimum, twice monthly monitoring at the work site to assess employment stability, unless the individualized vocational plan provides for off-site monitoring. If off-site monitoring is determined to be appropriate, it must, at a minimum, consist of two meetings with the individual and one contact with the employer each month. Eligible individuals must be 16 years of age or older, have previously resided in an ICF or ICF/MR and are unable to receive these services through the Department of Rehabilitation Services or through the state or local education agency.

(C) Coverage limitations. Reimbursement is based on the number of hours the recipient is employed at a rate of minimum wage or above with a maximum of 30 units per week per individual.

(11) Supported employment.

(A) Minimum qualifications. Supported employment providers:

- (i) are at least 18 years of age;
- (ii) complete the OKDHS DDSD sanctioned training curriculum;
- (iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and
- (iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education of full-time equivalent experience in serving persons with disabilities.

(B) Description of services. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members

receiving services through HCBS Waiver, including supervision and training.

(i) When supported employment services are provided at a work site in which persons without disabilities are employee, payment will:

(I) be made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) job coaching as specified in OAC 317:40-7-7;

(II) enhanced job coaching as specified in OAC 317:40-7-12;

(III) employment training specialist services as specified in OAC 317:40-7-8; and

(IV) stabilization as specified in OAC 317:40-7-11.

(iii) Supported employment services furnished under HCBS Waiver are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA will be maintained in the record of each member receiving this service.

(v) Federal financial participation (FFP) will not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) payments that are passed through to users of supported employment programs; or

(III) payments for vocational training that is not directly related to a member's supported employment program.

(C) Coverage limitations. A unit is 15 minutes and payment is made in accordance with OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported employment services combined cannot exceed \$25,000 per Plan of Care year. The case manager assists the member to identify other alternatives to meet identified needs above the limit.

(15) 12) Intensive Personal Supports personal supports (IPS).

(A) Minimum qualifications. Intensive Personal Supports IPS provider agencies must have current, valid contracts with OHCA and OKDHS/DDSD and ensure that any staff member providing Intensive Personal Supports has completed the training in accordance with OAC 340:100-3-38. Providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2;

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities; and

(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) Description of services.

(i) Intensive Personal Supports IPS:

(I) are support services provided to ~~Home-ward-Bound~~ class members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) Intensive Personal Supports build upon the level of support provided by a ~~Habilitation Training Specialist HTS~~ or ~~Daily Living Supports~~ daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.

(ii) The member's IP must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) Case management supervisor review and approval is required.

(C) Coverage limitations. Intensive Personal Supports IPS are limited to 24 hours per day and must be included in the class member's Individual Plan in accordance with IP per OAC 340:100-5-53, be authorized in the Plan of Care, and be provided in conjunction with Habilitation Training Services 317:40-5-151 and 317:40-5-153.

(16) 13) Adult Day Services day services.

(A) Minimum qualifications. Adult Day Service day services provider agencies must:

(i) meet the licensing requirements set forth by Section in 63 O.S. § 1-873 et seq. of Title 63 of the Oklahoma Statutes and comply with OAC 310:605, ~~Adult Day Care Centers~~; and

(ii) Provider agencies must also be approved by the OKDHS DDSD of OKDHS and have a valid OHCA contract for Adult Day Services adult day services.

(B) Description of services. Adult Day Services is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day services provide assistance with the retention or improvement of self-help, adaptive, and socialization skills, including the opportunity to interact with peers

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in order to promote maximum level of independence and function. Services are provided in a non-residential setting separate from the home or facility where the member resides.

(C) **Coverage limitations.** Services Adult day services are typically furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must be authorized in the service recipient's Individual Plan and reflected in the approved plan of care member's IP.

[OAR Docket #07-700; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-692]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-59 [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 10. Bariatric Surgery [NEW]
317:30-5-137 through 317:30-5-141 [NEW]
(Reference APA WF # 06-29)

AUTHORITY:

Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

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Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-59 [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 10. Bariatric Surgery [NEW]
317:30-5-137 through 317:30-5-141 [NEW]

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Agency rules are issued to establish coverage for bariatric surgery for SoonerCare members between the ages of eighteen to sixty-five with a body mass index of thirty-five or greater who have been diagnosed with one of the following conditions, diabetes mellitus, degenerative joint disease of at least one major weight bearing joint or have another co-morbid condition. The agency researched several options to weight loss programs and concluded the bariatric surgery has the best long term results. The following is an excerpt from the State of Washington clinical trial obtained by the agency as part of its research: Morbidly obese individuals have a 10%-28% incidence of type 2 non-insulin dependent diabetes. After surgery, 69%-100% of patients with diabetes had improvement or resolution of diabetes. One review concluded 76.8% of patients had complete diabetes resolution, and 86% had resolution improvement. Clinical trials demonstrated that surgery cured 11 or 12 diabetics in one study and freed 75% of patients of medication for diabetes in another. An average weight loss after surgery is 55-97 pounds after 1-2 years. Up to 8 years after surgery, there is an average 44 pound total loss. Rules are revised to add bariatric surgery as a covered Medicaid service.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-59. General program exclusions - adults

The following are excluded from Medicaid coverage for adults:

- (1) Inpatient diagnostic studies that could be performed on an outpatient basis.
- (2) Services or any expense incurred for cosmetic surgery.
- (3) Services of two physicians for the same type of service to the same patient at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.
- (4) Refractions and visual aids.

- (5) Separate payment for pre and post-operative care when payment is made for surgery.
- (6) Reversal of sterilization procedures for the purposes of conception.
- ~~(7) Treatment for obesity.~~
- ~~(8) Non therapeutic hysterectomies. Therapeutic hysterectomies require that the following information to be attached to the claim:~~
 - (A) a copy of an acceptable acknowledgment form signed by the patient, or,
 - (B) an acknowledgment by the physician that the patient has already been rendered sterile, or,
 - (C) a physician's certification that the hysterectomy was performed under a life-threatening emergency situation.
- ~~(9) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest.~~
- ~~(10) Medical services considered to be experimental.~~
- ~~(11) Services of a Certified Surgical Assistant.~~
- ~~(12) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.~~
- ~~(13) Services of a Registered Physical Therapist.~~
- ~~(14) Services of a Psychologist.~~
- ~~(15) Services of a Speech and Hearing Therapist.~~
- ~~(16) Payment for more than four outpatient visits per month (home, office, outpatient hospital) per patient, except those visits in connection with family planning or emergency medical condition.~~
- ~~(17) Payment for more than two nursing home visits per month.~~
- ~~(18) More than one inpatient visit per day per physician.~~
- ~~(19) Payment for removal of benign skin lesions unless medically necessary.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 10. BARIATRIC SURGERY

317:30-5-137. Eligible providers to perform bariatric surgery

The Oklahoma Health Care Authority (OHCA) covers bariatric surgery under certain conditions as defined in this section. Bariatric surgery is not covered for the treatment of obesity alone. To be eligible for reimbursement for bariatric surgery providers must be certified by the American College of Surgeons (ACS) as Level I Bariatric Surgery Center or certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) or the

surgeon and facility are currently participating in a bariatric surgery assurance program and a clinical outcomes assessment program. All qualifications must be met and approved by the OHCA. Bariatric surgery facilities and their providers must be contracted with OHCA.

317:30-5-138. General coverage

(a) After determining member requirements are met (see OAC 317:30-5-139) and receiving prior authorization from OHCA, the primary care provider coordinates a process to include:

(1) a comprehensive psychosocial evaluation including:

- (A) evaluation for substance abuse;
- (B) evaluation for psychiatric illness which would preclude the member from participating in pre-surgical dietary requirements or post surgical lifestyle changes;
- (C) if applicable, documentation that the member has been successfully treated for a psychiatric illness and has been stabilized for at least six months; and
- (D) if applicable, documentation that the member has been rehabilitated and is free from drug and/or alcohol for a period of at least one year.

(2) an independent medical evaluation performed by an internist who is contracted with the OHCA to assess the member's preoperative and mortality risks.

(3) a surgical evaluation by an OHCA contracted surgeon who has credentials to perform bariatric surgery.

(4) participation in a weight loss program prior to surgery, under the supervision of an OHCA contracted medical provider. The member must, within one hundred and eighty days from the approval of the OHCA's prior authorization, lose at least five percent of member's initial body weight.

(A) If the member does not meet the weight loss requirement in the allotted time the prior authorization is cancelled.

(B) The member's provider must reapply for prior authorization to restart the process if the requirement is not met.

(b) When all requirements have been met, a prior authorization for surgery must be obtained from OHCA. This authorization can not be requested before the initial 180 day weight loss program has been completed.

(c) The bariatric surgery facility or surgeon must, on an annual basis, provide to the OHCA the members statistical data which includes but is not limited to, mortality, hospital readmissions, re-operation, morbidity data and average weight loss.

(d) OHCA considers surgery to correct complications from bariatric surgery medically necessary, such as obstruction or stricture.

(e) OHCA considers repeat bariatric surgery medically necessary for a member whose initial bariatric surgery was medically necessary, and member meets either of the following criteria:

(1) has not lost more than fifty percent of excess body weight two years following the primary bariatric surgery

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procedure and is in compliance with prescribed nutrition and exercise programs following the procedure; or

(2) revision of a primary bariatric surgery procedure that failed due to dilation of the gastric pouch if the procedure was successful in inducing weight loss prior to the pouch dilation, and is in compliance with prescribed nutrition and exercise programs following the procedure.

(f) OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member or provider is not in compliance with any of the requirements.

317:30-5-139. Member requirements

Members must meet the following criteria to be eligible:

- (1) be between 18 and 65 years of age;
- (2) have body mass index (BMI) of thirty-five or greater;
- (3) be diagnosed with one of the following:
 - (A) diabetes mellitus;
 - (B) degenerative joint disease of a major weight bearing joint(s). The member must be a candidate for joint replacement surgery if weight loss is achieved;
 - or
 - (C) a rare co-morbid condition in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality.
- (4) have presence of obesity that has persisted for at least 5 years;
- (5) have attempted weight loss in the past without successful long term weight reduction, which must be documented by a physician;
- (6) have absence of other medical conditions that would increase the member's risk of surgical mortality or morbidity; and
- (7) the member is not pregnant or planning to become pregnant in the next two years.

317:30-5-140. Coverage for children

(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the OHCA Medicaid program. Such services must be prior authorized.

(b) Federal Medicaid regulations also require the state to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the state determines are not safe and effective or which are considered experimental.

317:30-5-141. Reimbursement

Payment is made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services.

[OAR Docket #07-692; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-707]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. General Provider Policies

Part 4. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program/Child Health Services

317:30-3-65.4 [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-25 [AMENDED]

(Reference APA WF # 06-17 and 06-09)

AUTHORITY:

Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

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Subchapter 3. General Provider Policies

Part 4. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program/Child Health Services

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Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-25 [AMENDED]

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24 Ok Reg 78

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(Reference APA WF # 06-09)

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) rules are revised to add coverage of environmental inspection service for children

with elevated blood lead levels. High blood levels can cause serious health effects, including seizures, coma and death. Elevated blood levels have been associated with adverse effects on cognitive development, growth, and behavior among children aged 1 to 5. Because children with elevated blood lead levels ranging from 10 to 25 ug/dL do not develop clinical symptoms, screening is necessary to identify children who need environmental or medical intervention to reduce their blood lead levels. The Oklahoma Childhood Lead Poison Prevention Program (OCLPPP), by and through the Oklahoma State Department of Health, provide educational assistance, case management services and environmental inspections to children who have elevated blood lead in accordance with rules set forth by the Oklahoma State Board of Health (OAC 310:512-3-5). Federal policy requires that all state Medicaid programs cover a one-time environmental investigation to determine the source of lead. Revisions provide Federal Financial Participation to this state funded program.

Physician rules are revised to add post-payment retrospective reviews of medical necessity for outpatient observation services. Currently, outpatient observation services are not a part of post payment review by the agency's Quality Improvement Organization. Revisions are needed to reduce potential abuses of observation services, as documented by the Office of Inspector General. The revised rules would reduce potential abuses and allow the agency to recoup erroneous payments.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES

317:30-3-65.4. Screening components

Comprehensive EPSDT screenings are performed by, or under the supervision of, a ~~certified Medicaid SoonerCare physician, dentist or other provider qualified under State law to furnish primary medical and health services.~~ SoonerCare physicians are defined as all licensed medical and osteopathic physicians, physician assistants and advanced practice nurses in accordance with the rules and regulations covering the OHCA's medical care program. At a minimum, screening examinations must include, but not be limited to, the following components:

- (1) **Comprehensive health and developmental history.** Health and developmental history information may be obtained from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:
 - (A) **Developmental assessment.** Developmental assessment includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for development assessment is a part of every routine, initial

and periodic screening examination. Acquire information on the child's usual functioning as reported by the child, teacher, health professional or other familiar person. Review developmental progress as a component of overall health and well-being given the child's age and culture. As appropriate, assess the following elements:

- (i) Gross and fine motor development;
- (ii) Communication skills, language and speech development;
- (iii) Self-help, self-care skills;
- (iv) Social-emotional development;
- (v) Cognitive skills;
- (vi) Visual-motor skills;
- (vii) Learning disabilities;
- (viii) Psychological/psychiatric problems;
- (ix) Peer relations; and
- (x) Vocational skills.

(B) **Assessment of nutritional status.** Nutritional assessment may include preventive treatment and follow-up services including dietary counseling and nutrition education if appropriate. This is accomplished in the basic examination through:

- (i) Questions about dietary practices;
- (ii) Complete physical examination, including an oral dental examination;
- (iii) Height and weight measurements;
- (iv) Laboratory test for iron deficiency; and
- (v) Serum cholesterol screening, if feasible and appropriate.

(2) **Comprehensive unclothed physical examination.** Comprehensive unclothed physical examination includes the following:

- (A) **Physical growth.** Record and compare height and weight with those considered normal for that age. Record head circumference for children under one year of age. Report height and weight over time on a graphic recording sheet.
- (B) **Unclothed physical inspection.** Check the general appearance of the child to determine overall health status and detect obvious physical defects. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

(3) **Immunizations.** Legislation created the Vaccine for Children Program to be effective October 1, 1994. Vaccines will be provided free of charge to all enrolled providers for Medicaid eligible children. Participating providers may bill for an administration fee to be set by CMS, formerly known as HCFA on a regional basis. They may not refuse to immunize based on inability to pay the administration fee.

(4) **Appropriate laboratory tests.** A blood lead screening test (by either finger stick or venipuncture) must be performed between the ages of nine and 12 months and at 24 months. A blood lead test is required for any child up to age 72 months who had not been previously screened. A blood lead test equal to or greater than ~~10ug/dL~~ 10ug/dL

micrograms per deciliter (ug/dL) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If a child is found to have blood lead levels equal to or greater than 10 ug/dL, providers are to use their professional judgment, with reference to Centers for Disease Control (CDC) guidelines covering patient management and treatment, including follow up blood tests and initiating investigations to the source of lead the Oklahoma Childhood Lead Poison Prevention Program (OCLPPP) must be notified according to rules set forth by the Oklahoma State Board of Health (OAC 310:512-3-5).

(A) The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater. Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from laboratories or providers and reimbursed through the OSDH cost allocation plan approved by OHCA.

(B) Medical judgment is used in determining the applicability of all other laboratory tests or analyses to be performed unless otherwise indicated on the periodicity schedule. If any laboratory tests or analyses are medically contraindicated at the time of the screening, they are provided when no longer medically contraindicated. Laboratory tests should only be given when medical judgment determines they are appropriate. However, laboratory tests should not be routinely administered. General procedures including immunizations and lab tests, such as blood lead, are outlined in the periodicity schedule found at OAC 317:30-3-65.2.

(5) **Health education.** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives the initial context for providing health education. Health education and counseling to parents, guardians or children is required. It is designed to assist in understanding expectations of the child's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

(6) **Vision and hearing screens.** Vision and hearing services are subject to their own periodicity schedules. However, age-appropriate vision and hearing assessments may be performed as a part of the screening as outlined in the periodicity schedule found at OAC 317:30-3-65.7 and 317:30-3-65.9.

(7) **Dental screening services.** An oral dental examination may be included in the screening and as a part of the nutritional status assessment. Federal regulations require a direct dental referral for every child in accordance with the periodicity schedule and at other intervals as medically necessary. Therefore, when an oral examination is done at the time of the screening, the child may be referred directly to a dentist for further screening and/or treatment. Specific dental services are outlined in OAC 317:30-3-65.8.

(8) **Child abuse.** Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: "Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of 18 years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of 18 years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above". Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought solely as a result of the filing of the report.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-25. Oklahoma Health Care Authority's Designated Agent Quality Improvement Organization (QIO)

All inpatient stays and outpatient observation services are subject to post-payment utilization review by the OHCA's designated Quality Improvement Organization (QIO) agent. These reviews ~~will be~~ are based on severity of illness and intensity of treatment.

(1) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission ~~and or~~ and/or extended stay or outpatient observation of a Medicaid-SoonerCare recipient member. If ~~OHCA's designated agent~~ the QIO, upon their initial review determines the admission or outpatient observation services should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted ~~in accordance with~~ within the specified time-frame on the notice and consistent with the Medicare ~~time frame~~ guidelines. Additional information submitted with the reconsideration request ~~will be~~ is reviewed by ~~OHCA's designated agent~~ the QIO who ~~that~~ utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, ~~OHCA is informed.~~ At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment

~~previously made on the denied admission the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.~~

(2) If the hospital or attending physician did not request reconsideration ~~by OHCA's designated agent from the QIO, the designated agent QIO~~ informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, ~~sends a letter to the hospital and physician informing of recoupment of Medicaid payment previously made on the denied admission~~ processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(3) If the ~~designated agent's QIO's~~ review results in denial and the denial is upheld throughout the review process and refund from the hospital and physician is required, the ~~Medicaid SoonerCare recipient member~~ cannot be billed for the denied services.

(4) If a hospital or physician believes a hospital admission, ~~or continued stay, or outpatient observation service~~ is not medically necessary and thus not ~~Medicaid SoonerCare~~ compensable but the ~~patient member~~ insists on treatment, the ~~patient member should be~~ is informed that he/she will be personally responsible for all charges.

(A) If a ~~Medicaid SoonerCare~~ claim is filed and paid and the service is later denied ~~after medical necessity review~~, the ~~patient member~~ is not responsible.

(B) If a ~~Medicaid SoonerCare~~ claim is not filed, the ~~patient member~~ can be billed.

[OAR Docket #07-707; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-702]

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PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-12 [AMENDED]
317:30-5-22 [AMENDED]
317:30-5-24 [AMENDED]
Part 19. Nurse Midwives
317:30-5-226 [AMENDED]
Part 35. Rural Health Clinics
317:30-5-355.1 [AMENDED]
317:30-5-361 [AMENDED]
Part 49. Family Planning Centers
317:30-5-466 [AMENDED]
317:30-5-467 [AMENDED]
Part 89. Radiological Mammographer
317:30-5-901 [AMENDED]
(Reference APA WF # 06-28 and 06-22)

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317:30-5-24 [AMENDED]
Part 19. Nurse Midwives
317:30-5-226 [AMENDED]
Part 35. Rural Health Clinics
317:30-5-355.1 [AMENDED]
317:30-5-361 [AMENDED]
Part 49. Family Planning Centers
317:30-5-466 [AMENDED]
317:30-5-467 [AMENDED]
Part 89. Radiological Mammographer
317:30-5-901 [AMENDED]

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rules are revised to allow coverage for first trimester ultrasounds and additional ultrasounds as needed for high risk pregnancies. Through the use of high risk ultrasounds, the provider can more accurately determine the estimated due date which enhances the probability of positive birth outcomes. Current rules do not allow for first trimester ultrasounds nor does it allow for an adequate number of follow up ultrasounds for women with established serious pregnancy conditions or complications. Therefore, rules revisions are needed to enhance the probability of positive birth outcomes through coverage of additional ultrasounds.

Permanent Final Adoptions

Agency rules are revised to allow mammograms for members of any age or gender when they are medically indicated as necessary. Currently rules allow for one screening and one follow-up mammogram annually for women beginning at age 30. The current language is not in line with benefits offered through the Breast and Cervical Cancer (BBC) Program and could limit medically necessary mammograms for members with cancerous conditions. Rules are also revised to remove the contraceptive Norplant system from benefits as it is no longer offered. Changes also reflect organ transplant clarifications as outlined in APA WF# 06-38 submitted this same date.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-12. Family planning

- (a) Pregnancy tests are covered.
- ~~(b) Physician services are covered for insertion and removal of Levonorgestrel implant—Norplant System, including payment for Norplant System Kit. It is anticipated, when the Norplant System is the contraceptive of choice, that the client will be counseled regarding the long term nature of this contraceptive system. Removal of the Norplant capsules prior to five years will be covered for medically necessary reasons only. Removal of the Norplant capsules is not covered for the convenience of the client or for purposes of conception. Reinsertion of Norplant contraceptive will be considered on a case by case basis.~~
- ~~(e**b**)~~ Reverse vasectomy is not covered.
- ~~(d**c**)~~ Reversal of sterilization procedures for the purpose of conception are not covered.

317:30-5-22. Obstetrical care

- (a) Obstetrical (OB) care ~~should be~~ is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery ~~should be~~ is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the patient member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

- (b) Procedures paid separately from total obstetrical care are listed in (1) - (6) of this subsection.

~~(1) **Level I—Complete Ultrasound:** Payment will be made separately from the total obstetrical care for one complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used. The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form and the most recent version of the Oklahoma Health Care Authority (OHCA), Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record.~~

~~(2) **Level II—Targeted Ultrasound:** Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed. Medically necessary real time ante partum diagnostic ultrasounds will be paid for in addition to ante partum care, delivery and post partum obstetrical care under defined circumstances. To be eligible for payment, ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).~~

~~(A) with equipment capable of producing targeted quality evaluations; and One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in Obstetrical ultrasonography.~~

~~(B) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine or an active candidate for certification in maternal fetal medicine. One ultrasound after the first trimester will be covered. This ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in Obstetrical ultrasonography.~~

~~(C) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary. Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal~~

anomalies, must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine.

- (3) Standby attendance at ~~C-Section~~ Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.
- (4) Spinal anesthesia administered by the attending physician is a compensable service and ~~should be~~ is billed separately from the delivery.
- (5) Amniocentesis is not included in routine obstetrical care and ~~should be~~ is billed separately.
- (6) Additional payment is not made for the delivery of twins. If one twin is delivered vaginally and one is delivered by C-section by the same physician, the higher level procedure is paid. If one twin is delivered vaginally and one twin delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment ~~will is~~ is not be made to the same physician for both standby and assistant at C-Section.
- (c) Assistant surgeons ~~will be~~ are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section should bill separately for the prenatal and the six weeks postpartum office visit.
- (d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total obstetrical care.
 - (1) An additional allowance ~~may is~~ is not be made for induction of labor, double set-up examinations, fetal stress and non-stress tests, or pudendal anesthetic. Do not bill separately for these procedures.
 - (2) Standby at C-Section is not compensable when billed by a physician participating in delivery.
 - (3) Payment is not made for assistant surgery for obstetrical procedures which include prenatal or post partum care.
 - (4) Pitocin induction of labor is considered part of the delivery and separate payment is not made.
 - (5) Fetal scalp blood sampling is considered part of the total OB care.
- (e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.
 - (1) Services, deemed medically necessary and allowable under federal Medicaid regulations, are covered by the EPSDT/OHCA Child Health program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.
 - (2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

317:30-5-24. Radiology

(a) **Outpatient and emergency department.**

- (1) The technical component of outpatient radiological services performed during an emergency department visit is included in the emergency department ~~ease~~ all inclusive payment rate on a per visit basis which is paid to the hospital.
- (2) The professional component of x-rays performed during an emergency department visit is covered.
- (3) ~~Payment will be made separately from the total obstetrical care for one Level I complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used. Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed: Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A-C).
 - (A) ~~with equipment capable of producing targeted quality evaluations; and~~
 - (B) ~~by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine.~~
 - (C) ~~a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.~~~~
- (4) ~~Outpatient chemotherapy is compensable for proven malignancies and opportunistic infections. Outpatient radiation therapy is covered for the treatment of proven malignancies or when treating benign conditions utilizing stereotactic radiosurgery (e.g., gamma knife). Payment is made for charges incurred for the administration of chemotherapy for the treatment of medically necessary and medically approved procedures. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).~~
- (5) ~~One Medically necessary screening mammogram and one follow up mammogram every year for women beginning at age 30 mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow up mammograms.~~
- (b) **Inpatient procedures.** Inpatient radiological procedures are compensable if done on a referral basis. Claims for inpatient interpretations by the attending physician are not compensable unless the attending physician reads interpretations for the hospital on all patients.
- (c) **Inpatient radiology performed outside of hospital.** When ~~patient a~~ member is an inpatient but has to be taken elsewhere for an x-ray, such as to an office or another hospital because the admitting hospital did not have proper equipment, the place of service ~~should~~ must still be ~~in inpatient hospital,~~

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since the patient member is considered to be in the hospital at the time of service.

(d) **Radiology therapy management.** Weekly clinical management is based on five fractions delivered comprising one week regardless of the time interval separating the delivery of treatments. Weekly clinical management ~~should~~ must be billed as one unit of service rather than five.

(e) **Miscellaneous.**

(1) **Arteriograms, angiograms and aortograms.** When arteriograms, angiograms or aortograms are performed by a radiologist, they are considered radiology, not surgery.

(2) **Injection procedure for arteriograms, angiograms and aortograms.** The "interpretation only" code and the "complete procedure" code are not both allowed for one of these procedures.

(3) **Evac-U-Kit or Evac-O-Kit.** Evac-U-Kit and Evac-O-Kit are included in the charge for the Barium Enema.

(4) **Examination.** Examination at bedside or in operating room allows an additional charge to be made. Examination outside regular hours is not a covered charge.

(5) **Supplies.** Separate payment is not made for supplies such as "administration set" used in provision of office chemotherapy.

(6) **Fluoroscopy or Esophagus study.** Separate charge for fluoroscopy or esophagus study in addition to a routine gastrointestinal tract examination is not covered unless a report is submitted indicating an esophagram was done as a separate procedure.

(f) **Magnetic Resonance Imaging.** MRI/MRA scans are covered when medically necessary. Documentation in the progress notes must reflect the medical necessity. The diagnosis code must be shown on the claim.

(g) **Placement of radium or other radioactive material.**

(1) For Radium Application use the appropriate HCPCS code.

(2) When a physician supplies the therapeutic radionuclides (implant grains or Gold Seeds) and provides a copy of the invoice, payment ~~will be~~ is made at 100% of the invoice charges. Fee ~~may~~ must include cost of radium, container, and shipping and handling.

PART 19. NURSE MIDWIVES

317:30-5-226. Coverage by category

(a) **Adults.** Payment is made for nurse midwife services including management of normal care of the mother and newborn(s) throughout the maternity cycle.

(1) The county ~~DHS~~ OKDHS office where the mother resides must be notified in writing within five days of the child's birth in order for an individual person code to be assigned to the newborn. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code will be denied.

(3) Providers must use ~~DHS~~ OKDHS Form FSS-NB-1 to notify the county DHS office of the child's birth.

(4) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. ~~Show the~~ The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the patient member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

~~(5) It is anticipated, when the Norplant System is the contraceptive of choice, that the client will be counseled regarding the long term nature of this contraceptive system. Removal of the Norplant capsules prior to five years will be covered for medically necessary reasons only. Removal of the Norplant capsules is not covered for the convenience of the client or for purposes of conception. Reinsertion of Norplant contraceptive will be considered on a case by case basis).~~

(b) **Children.** Payment to nurse midwives for services to children is the same as for adults.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

PART 35. RURAL HEALTH CLINIC

317:30-5-355.1. Definition of services

The RHC benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), part 440.20, consists of two components: RHC Services and Other Ambulatory Services.

(1) **RHC services.** RHC services ~~may be~~ are covered when furnished to a patient member at the clinic or other location, including the patient's member's place of residence. In all instances where possible, ~~Medicaid~~ SoonerCare defines a Rural Health Clinic service the same as Medicare as set out in Information Bulletin 93-15 issued by Blue Cross/Blue Shield of Oklahoma, Medicare Part A. These services are described in this Section.

(A) **Core services.** As set out in Federal Regulations at 42 CFR 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

- (iii) Services of advanced practice nurses (APNs), physician assistants (PAs), nurse midwives (NMs) or specialized advanced practice nurse practitioners;
- (iv) Services and supplies incident to the services of APNs and PAs (including services furnished by nurse midwives);
- (v) Visiting nurse services to the homebound;
- (vi) Clinical psychologist (CP) and clinical social worker (CSW) services;
- (vii) Services and supplies incident to the services of CPs and CSWs; and
- (viii) Laboratory tests essential to the immediate diagnosis and treatment of the patient member including:
 - (I) chemical examinations of urine by stick or tablet,
 - (II) hemoglobin or hematocrit,
 - (III) blood sugar,
 - (IV) examination of stool specimens for occult blood,
 - (V) pregnancy tests,
 - (VI) primary culturing for transmittal to a certified laboratory;

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APN, PA and NMW which would be covered as RHC services under Medicare, certain primary preventive services ~~may be~~ are covered under the Medicaid SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of a RHC practitioner who is a clinic employee:

- (i) prenatal and postpartum care;
- (ii) screening examination under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for ~~persons~~ members under 21;
- (iii) family planning services;
- (iv) medically necessary screening mammogram mammography and follow-up mammograms when medically necessary for women beginning at age 30.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker ~~may be~~ are covered if the service or supply is:

- (i) ~~of~~ a type commonly furnished in physicians' offices;
- (ii) ~~of~~ a type commonly rendered either without charge or included in the rural health clinic's bill;
- (iii) furnished as an incidental, although integral, part of a physician's professional services;
- (iv) A separate charge is allowable for immunizations covered under EPSDT. Also, injections not otherwise discussed below ~~may~~ must be billed separately using the appropriate HCPC codes. However, drugs and biologicals which cannot be

self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services ~~may be~~ are covered if:

- (i) the RHC is located in an area in which the ~~Health Care Financing Administration (HCFA)~~ Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;
- (ii) the services are rendered to ~~patients~~ members who are homebound;
- (iii) the patient member is furnished nursing care on a part time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
- (iv) the services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and a RHC health professional (i.e., physicians, physician assistants, advanced practice nurses, nurse midwives, clinical psychologists and clinical social workers). Encounters with more than one health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the patient member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that Medicaid SoonerCare reimbursement ~~will be~~ is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The rural health clinic ~~should~~ must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the rural health clinic services provided off-site are to be billed to Medicaid SoonerCare. It is expected that services provided in off-site settings ~~should be~~ are, in most cases, temporary and intermittent, i.e., when the ~~client~~ member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** A Rural Health Clinic ~~may~~ must provide other items and services which are not "RHC services" as described in (a)(1) of this Section, and are separately billable to the Medicaid SoonerCare program. Coverage of services ~~will be~~ are based upon the scope of coverage under the Medicaid SoonerCare program.

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(A) Other ambulatory services include, but are not limited to:

- (i) dental services for ~~persons~~ members under age 21;
- (ii) optometric services;
- (iii) clinical lab tests performed in the RHC lab (other than the specific laboratory tests set out for RHC certification and covered as RHC services);
- (iv) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
- (v) durable medical equipment;
- (vi) emergency ambulance transportation;
- (vii) prescribed drugs;
- (viii) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
- (ix) specialized laboratory services furnished away from the clinic;
- (x) inpatient services;
- (xi) outpatient hospital services.

(B) Payment ~~may be~~ is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for ~~persons~~ members under age 21. Encounters ~~may be~~ are billed as one of the following:

- (i) **EPSDT dental screening.** An EPSDT dental screening ~~will include~~ includes oral examination, prophylaxis and fluoride treatment, ~~and~~ charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.
- (ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.
- (iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses ~~may must~~ be billed separately.

(C) Services listed in (a)(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the OHCA. Service item (a)(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the Medicaid Sooner-Care program by the provider rendering the service.

Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one type of encounter per ~~recipient~~ member per day. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPC or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date ~~patient~~ the member was is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes ~~may be~~ are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.

(b) **Services ~~which may be~~ billed separately from encounters.** Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges.

(1) **Laboratory.** The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services which are not included in the all-inclusive rate must be itemized separately using the appropriate CPT or HCPCS code.

(2) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(3) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(4) **Contraceptives.** Contraceptives ~~may be~~ are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:

- (A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).

~~(B) Insertion, implantable contraceptive capsules and implantation of a subdermal contraceptive device~~

~~(C) Removal, implantable contraceptive capsules devices. (It is anticipated, when the Norplant System is the contraceptive of choice, that the client will be counseled regarding the long term nature of this contraceptive system. Removal of the Norplant capsules prior to five years will be covered for medically necessary reasons only. Medically necessary is defined as having absolute contraindications as listed in the Physicians' Desk Reference (PDR) or the insert material provided with the Norplant system. Removal of the Norplant capsules is not covered for the convenience of the client or for purposes of conception. Reinsertion of Norplant contraceptive will be considered on a case by case basis).~~

~~(D) Removal, with reinsertion, implantable contraceptive capsules device.~~

~~(E) Norplant, system kit.~~

~~(F) Insertion of intrauterine device (IUD).~~

~~(G) Removal of intrauterine device.~~

~~(H) ParaGard IUD.~~

~~(I) Progestasert IUD.~~

(5) **Glasses.** Glasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code.

PART 49. FAMILY PLANNING CENTERS

317:30-5-466. Coverage by category

Payment is made to family planning centers as set forth in this Section.

(1) **Adults.** Payment is made for adults on an encounter basis. Each encounter is all inclusive of the following and payment includes all services provided:

(A) **Initial examination services.** Initial examination services that are provided to new family planning patients include:

(i) Complete physical examination including assessment of height, weight, blood pressure, thyroid, extremities, heart, lungs, breasts, abdomen, pelvic examination, including visualization of the cervix, external genitalia, bimanual exam, and rectal exam as indicated. (Male clients receive examination of genitals and rectum including palpation of the prostate in lieu of pelvic exam given females.)

(ii) Complete general history of patient and pertinent history of immediate family members. This general history addresses allergies, immunizations, past illnesses, hospitalizations, surgery, review of systems, use of alcohol, tobacco and drugs. Reproductive function history in female patients includes menstrual history, sexual activity, sexually transmitted diseases, contraceptive use, pregnancies, and in utero exposure to DES. Male

reproductive general history includes sexual activity, sexually transmitted diseases, fertility, and exposure to DES.

(iii) Laboratory services to include hematocrit, dip stick urinalysis, pap smear, gonorrhea culture, serologic test for syphilis and rubella screening if indicated.

(iv) Education and counseling are offered to provide information regarding reproductive anatomy, range of clinic services, risks benefits and side effects of various methods of contraception, and health promotion/disease prevention topics as needed.

(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.

(vi) Treatment of minor gynecological problems, infections, and other conditions.

(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(B) **Annual examination services.** Annual examination services are provided to continuing patients to include:

(i) Annual update physical examination to include height, weight, blood pressure, extremities, and examination of breasts and pelvic organs. If required, a complete physical examination may be provided as described under the initial visit services above.

(ii) A medical history update is taken to update the general history and includes noting the patient's adaptation to and correct use of contraceptive method, menstrual history, specific warning signs and other side effects related to the contraceptive method. If indicated, a complete general history of the patient will be taken at the annual visit.

(iii) Laboratory services to include pap smear, gonorrhea culture, hematocrit, and serologic test for syphilis.

(iv) Education and counseling regarding specific problems, risks and side effects of the method in use.

(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.

(vi) Treatment of minor gynecological problems, infections, and other conditions.

(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(C) **Encounter visits.**

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(i) Encounter visits covers services provided to patients which are not part of the initial/annual examinations. This may include:

(I) A follow-up visit for all new patients to insure they understand and are experiencing no problems with their particular contraceptive method.

(II) A scheduled revisit for a new or continuing patient who may have conditions which places the patient in a high risk category requiring more intensive medical management as outlined in the program medical protocol.

(ii) Encounter visits may also be scheduled at the request of the patient as they are encouraged to return to the clinic at any time they experience difficulty with a particular contraceptive method or have concerns related to their reproductive health. Pregnancy diagnosis and counseling services are also provided under this category.

(D) **Vasectomy.** For vasectomies, payment will be made as an all-inclusive rate for all services provided in connection with the surgery. Claims must have the Federally mandated consent form properly completed and attached.

(E) **Tubal ligations.** For tubal ligations, payment will be made as an all-inclusive rate for the cost of the surgeon, anesthesiologist, pre and post-operative care and outpatient surgery facility. Claims must have the properly completed Federally mandated consent form attached.

~~(F) **Norplant system kit.** This is a levonorgestrel implant that is used as a long term reversible contraceptive method that provides continuous contraception for as long as five years.~~

~~(i) The Levonorgestrel implant of Norplant system is a minor in office surgical procedure for implanting the Norplant System consisting of six flexible capsules.~~

~~(ii) Removal of the Levonorgestrel Norplant System is a minor in office surgical procedure for the removal of the Norplant System.~~

(2) **Children.** Payment is made for children as set forth for adults. However payment cannot be made for the sterilization of persons under the age of 21.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

317:30-5-467. Coverage limitations

(a) Sterilizations require proper consent form and are not compensable for patients under 21 years of age.

(b) The following coverage limitations apply to services provided by family planning centers:

(1) Service: Initial Examination; Unit: Completed Examination and Services; Limitation: one initial examination.

(2) Service: Annual; Unit: Completed Examination and Services; Limitation: one annual examination.

(3) Service: Encounter Visit; Unit: Completed Examination and Services; Limitation: one per day.

(4) Service: Vasectomy; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).

(5) Service: Tubal Ligation; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).

~~(A) Norplant System; One kit; One every 5 years.~~

~~(B) Levonorgestrel Implant Norplant System; Completed Examination and Services; One every 5 years.~~

~~(C) Removal of Levonorgestrel Norplant System; Completed Examination and Services; One every 5 years.~~

PART 89. RADIOLOGICAL MAMMOGRAPHER

317:30-5-901. Coverage by category

~~(a) **Adults.** Payment to mammographers is limited to one Medically necessary screening mammogram and one follow up mammogram provided once every year to eligible women beginning at age 30 mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow up mammograms.~~

~~(b) **Children.** There is no coverage for children except as set out under EPSDT. Coverage for children is the same as for adults.~~

[OAR Docket #07-702; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-708]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-13 [AMENDED]

Part 5. Pharmacists

317:30-5-70.2 [AMENDED]

(Reference APA WF #06-16 and 06-03)

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N/A

ANALYSIS:

Physician rules are revised to clarify reimbursement guidelines for rape and abuse exams. Language is added to specify that medically necessary procedures as well as the exam are compensable. Revisions reflect the current form and terminology used when billing for these services. Rule revisions are needed to provide consistency in rules and to reduce the Medicaid provider error rate.

Pharmacists rules are revised to clarify the record retention rule to providers and outside reviewers. There has been some confusion as to the interpretation of "original written prescription". The provider is required to provide original written prescriptions along with other documents at the time of an audit. The rule revision provides the definition of "original written prescription" as defined in the Oklahoma Pharmacy Act. This clarification will eliminate confusion of the interpretation and could eliminate any potential audit findings due to misinterpretation of the required documents.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-13. Rape and abuse exams

When a rape/abuse exam is performed on a child with an active medical assistance case number or included in an active AFDC grant SoonerCare benefits, a claim should be filed with the fiscal agent. Payment is made for the rape/abuse exam and medically necessary procedures as per recognized coding guidelines.

(1) Supplies used during an exam for rape or abuse may be billed. Use appropriate HCPCS and diagnosis codes are used.

(2) If the child is in custody as reported by the Oklahoma Department of Human Services but does not have an active case number SoonerCare benefits, or the child is not in custody and the parents are unable or unwilling to assume payment responsibility, the caseworker social worker obtains from the physician a completed OKDHS form 10AD012, Claim Form ADM-12. The ADM-12 10AD012 form is routed according to procedures established by the Oklahoma Department of Human Services, Division of Children, Youth and Family Services.

PART 5. PHARMACISTS

317:30-5-70.2. Record retention

Pharmacies are selected at random for audits. The Pharmacy is required to provide original written prescriptions and signature logs as well as purchase invoices and other records necessary to document their compliance with program guidelines at the time of the audit. Original written prescriptions are defined as any order for drug or medical supplies written or signed, or transmitted by word of mouth, telephone or other means of communication by a practitioner licensed by law to prescribe such drugs and medical supplies intended to be filled, compounded, or dispensed by a pharmacist. Signature logs are defined as any document which verifies that the prescription was delivered to the member or their representative. This may include electronic forms of tracking including but not limited to scanning a bar code of the filled prescription. The electronic tracking system must be able to produce a copy of the scan for audit purposes. Failure to provide the requested information to the Authority Reviewer may result in a recommendation ranging from a potential recoupment of Medicaid's payment Medicaid payments for the service to contract termination.

[OAR Docket #07-708; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-711]

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RULES:

Subchapter 5. Individual Providers and Specialities

Part 1. Physicians

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Subchapter 5. Individual Providers and Specialities

Part 1. Physicians

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Rules revisions are needed to allow coverage for adult immunizations for vaccine preventable diseases. By maintaining recommended vaccines, SoonerCare members, their families and communities are protected from serious and often life threatening infections. Revisions provide advice and guidance on the most effective means to prevent vaccine-preventable diseases.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-14. Injections

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for ~~Medicaid~~ SoonerCare. OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The Authority covers any drug for its approved purpose that has been approved by the Food and Drug Administration (FDA). Administration of injections is paid in addition to the medication.

(1) **Immunizations for children.** An administration fee will be paid for vaccines administered by providers participating in the Vaccines for Children Program. When the vaccine is not included in the program, the administration fee is included in the vaccine payment. Payment will not be made for vaccines covered by the Vaccines for Children Program.

(2) **Immunizations for adults.** Coverage for adults is ~~limited to:~~ provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines.

~~(A) influenza immunizations;~~

~~(B) Pneumococcal Immunizations, and~~

~~(C) Gamma Globulin and Hepatitis A Vaccine when documentation shows the individual has been exposed to Hepatitis.~~

(b) The following drugs, classes of drugs or their medical uses are excluded from coverage:

(1) Agents used for the treatment of anorexia, weight gain, or obesity;

(2) Agents used to promote fertility;

(3) Agents used to promote hair growth;

(4) Agents used for cosmetic purposes;

(5) Agents used for the symptomatic relief of coughs and colds. Cough and cold drugs are not covered;

(6) Agents that are experimental or whose side effects make usage controversial; and

(7) Vitamins and Minerals with the following exception:

(A) Vitamin B-12 is covered only when there is a documented occurrence of malabsorption disease;

(B) Vitamin K injections are compensable; and

(C) Iron injections when medically necessary and documented by objective evidence of failure to respond to oral iron.

(c) Use the appropriate HCPC code when available. When drugs are billed under miscellaneous codes, a paper claim must be filed. The claims must contain the drug name, strength, dosage amount, and National Drug Code (NDC).

(d) Payment is made for allergy injections for adults and children. When the contracted provider actually administers or supervises the administration of the injection, the administration fee is compensable. No payment is made for administration when the allergy antigen is self-administered

by the patient member. When the allergy antigen is purchased by the physician, payment is made by invoice attached to the claim.

(e) Rabies vaccine, Imovax, Human Diploid and Hyperab, Rabies Immune Globulin are covered under the vendor drug program and may be covered as one of the covered prescriptions per month. Payment can be made separately to the physician for administration. If the vaccine is purchased by the physician, payment is made by invoice attached to the claim.

(f) Trigger point injections (TPI's) are covered using appropriate CPT codes. Modifiers are not allowed for this code. Payment is made for up to three injections (3 units) per day at the full allowable. Payment is limited to 12 units per month. The medical records must clearly state the reasons why any TPI services were medically necessary. All trigger point records must contain proper documents and be available for review. Any services beyond 12 units per month or 36 units per 12 months will require mandatory review for medical necessity. Medical records must be automatically submitted with any claims for services beyond 36 units.

(g) If a physician bills separately for surgical injections and identifies the drugs used in a joint injection, payment will be made for the cost of the drug in addition to the surgical injection. The same guidelines apply to aspirations.

(h) When IV administration in a Nursing Facility is filed by a physician, payment may be made for medication. Administration should be done by nursing home personnel.

(i) Intravenous fluids used in the administration of IV drugs are covered. Payment for the set is included in the office visit reimbursement.

[OAR Docket #07-711; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-713]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialities
Part 3. Hospitals
317:30-5-40 [AMENDED]
317:30-5-40.1 [NEW]
317:30-5-40.2 [NEW]
317:30-5-41 [AMENDED]
317:30-5-41.1 [NEW]
317:30-5-42 [REVOKED]
317:30-5-42.1 through 317:30-5-42.18 [NEW]
317:30-5-47 [AMENDED]
317:30-5-47.1 through 317:30-5-47.4 [AMENDED]
317:30-5-50 [AMENDED]
317:30-5-56 through 317:30-5-57 [NEW]
Part 63. Ambulatory Surgical Centers
317:30-5-566 [AMENDED]
317:30-5-567 [AMENDED]
(Reference APA WF # 06-33)

AUTHORITY:

Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

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Subchapter 5. Individual Providers and Specialities
Part 3. Hospitals
317:30-5-40 [AMENDED]
317:30-5-40.1 [NEW]
317:30-5-40.2 [NEW]
317:30-5-41 [AMENDED]
317:30-5-41.1 [NEW]
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317:30-5-47.1 through 317:30-5-47.4 [AMENDED]
317:30-5-50 [AMENDED]
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Part 63. Ambulatory Surgical Centers
317:30-5-566 [AMENDED]
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N/A

ANALYSIS:

Rules are revised to clarify and more accurately reflect utilization and costs for outpatient hospital services and freestanding ambulatory surgery centers. Rules are needed to establish accurate reimbursement and provide clarification to rules for outpatient hospital services for dates of service on or after October 1, 2005. Other revisions adopt the procedures and groupings paid by Medicare under the Ambulatory Surgery Center (ASC) system. This revision applies to hospital-based and freestanding ASC's. Revisions also establish clinic services and observation room services based on Ambulatory Patient Classification (APC) groups. Additional revisions are incorporated to agree with mammogram and organ transplant rules submitted for approval to the Governor this date in APA WF # 06-22 and 06-38.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTION 308.1(A), WITH AN EFFECTIVE DATE
OF MAY 11, 2007:**

Permanent Final Adoptions

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-40. Eligible providers

To be eligible for reimbursement all licensed acute care general and rehabilitation hospitals must be Medicare certified and have a current contract on file with the Oklahoma Health Care Authority (OHCA). Children specialty hospitals must be appropriately licensed and certified and have a current contract with the OHCA.

(a) All general medical/surgical hospitals and critical access hospitals eligible for reimbursement under this Part must be licensed by the appropriate state survey agency, meet Medicare conditions of participation, and have a current contract on file with the Oklahoma Health Care Authority (OHCA).

(b) Children specialty hospitals must be appropriately licensed and certified and have a current contract with the OHCA.

(c) Eligibility requirements for specialized rehabilitation hospitals are covered in OAC 317:30-5-110; inpatient psychiatric hospitals are covered in OAC 317:30-5-95. Requirements for long term care hospitals are found in OAC 317:30-5-60.

(d) Certain providers who provide professional and other services within an inpatient or outpatient hospital require separate contracts with the OHCA.

(e) Reimbursement for laboratory services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from the Center for Medicare and Medicaid Services (CMS) and have a current contract on file with this Authority.

317:30-5-40.1. General information

(a) This Chapter applies to coverage in an inpatient and/or outpatient setting. Coverage is the same for adults and children unless otherwise indicated.

(b) **Professional Services.** Payment is made to a participating hospital group or corporation for hospital based physician's services. The hospital must have a Hospital Group Physician's Contract with OHCA for this method of billing.

(c) **Prior Authorization.** OHCA requires prior authorization for certain procedures to validate the medical need for the service.

(d) **Medical necessity.** Medical necessity requirements are listed at OAC 317:30-3-1(f).

317:30-5-40.2. Definitions

The following words and terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise.

"CMS" means the Center for Medicare and Medicaid Services

"**Diagnosis Related Group**" means a patient classification system that relates types of patients treated to the resources they consume.

317:30-5-41. Inpatient hospital coverage/limitations for adults

(a) For persons 21 years of age or older, payment is made to hospitals for services as described in this Section. Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC:317:30:5-40.1(a) or (b). Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care or critical access hospitals are reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.

(+) Inpatient hospital services.

(A) Effective August 1, 2000, all general inpatient hospital services for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.

(B) Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care hospitals will no longer be subject to the 24 days per person per fiscal year limit. Claims will be reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.

(C) All inpatient services are subject to post payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

- (ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission.
- (iii) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.
- (D) If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.
- (E) Payment is made to a participating hospital for hospital-based physician's services. The hospital must have a Hospital-Based Physician's Contract with OHCA for this method of billing.
- (2) **Outpatient hospital services.**
 - (A) **Emergency hospital services.** Emergency department services are covered. Payment is made at a case rate which includes all non-physician services provided during the visit.
 - (B) **Level I-Complete Ultrasound.** Payment will be made separately from the total obstetrical care for one complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used.
 - (C) **Level II-Targeted Ultrasound.** Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed:
 - (i) with equipment capable of producing targeted quality evaluations; and
 - (ii) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine or an active candidate for certification in maternal fetal medicine.
 - (iii) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.
 - (D) **Dialysis.** Payment for dialysis is made at the Medicare allowable facility rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure, such as routing medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen).
 - (E) **Technical component.** Payment is made for the technical component of outpatient radiation therapy and compensable x ray procedures.
 - (F) **Laboratory.** Payment is made for medically necessary outpatient services.
 - (G) **Blood.** Payment is made for outpatient blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood.
 - (H) **Ambulance.**
 - (I) **Pharmacy.**
 - (J) **Home health care.** Hospital-based home health providers must be Medicare certified and have a current Home Health Agency contract with the Oklahoma Health Care Authority.
 - (i) Payment is made for home health services provided in a patient's residence to all categorically needy individuals.
 - (ii) Payment is made for a maximum of 36 visits per year per eligible recipient.
 - (iii) Payment is made for standard medical supplies.
 - (iv) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.
 - (v) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).
 - (vi) Payment may be made at a statewide procedure based rate. Payment for any combination of skilled and home health aide visits shall not exceed 36 visits per year.
 - (vii) Payment may be made to home health agencies for prosthetic devices.
 - (I) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. A completed HCFA 484 must accompany the initial claim for oxygen. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate. Refer to the Medical Suppliers Manual for further information.
 - (II) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.
 - (III) Sterile tracheostomy trays are covered.
 - (IV) Payment is made for colostomy and urostomy bags and accessories.

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- (V) Payment is made for hyperalimentation, including supplements, supplies and equipment rental in behalf of persons having permanently inoperative internal body organ dysfunction. CC 17 should be submitted to the Medical Authorization Unit. Information regarding the patient's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached.
- (VI) Payment is made for ventilator equipment and supplies when prior authorized. CC 17 should be submitted to the Medical Authorization Unit.
- (VII) Medical supplies, oxygen, and equipment should be billed using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.
- (K) **Outpatient hospital services, not specifically addressed.** Outpatient hospital services, not specifically addressed, are covered for adults only when prior authorized by the Medical Professional Services Unit of the Oklahoma Health Care Authority.
- (L) **Outpatient chemotherapy and radiation therapy.** Payment is made for charges incurred for the administration of chemotherapy for the treatment of malignancies and opportunistic infections. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).
- (M) **Ambulatory surgery.**
- (i) **Definition of Ambulatory Surgical Center.** An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients and which enters into an agreement with HCFA to do so. An ASC may be either independent (i.e., not part of a provider of services or any other facility) or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient hospital facility. In order to be covered as an ASC operated by a hospital, a facility must:
- (I) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;
- (II) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and
- (III) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.
- (ii) **Certification.** In order to be eligible to enter into an agreement with HCFA to be covered as

an ASC, a facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.

(N) **Outpatient surgery services.** The covered facility services are defined as those services furnished by an ASC or OHF in connection with a covered surgical procedure.

(i) **Services included in the facility reimbursement rate.** Services included in the facility reimbursement rate are:

(I) Nursing, technical and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.

(II) Use of the patient of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

(III) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures, including any drugs and biologicals administered while the patient is in the facility. Surgical dressings, other supplies, splints, and casts include those furnished by the facility at the time of surgery. Additional supplies and materials furnished later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the patient and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

(IV) Diagnostic or therapeutic items and services directly related to the surgical procedure. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.

(V) Administrative, recordkeeping, and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.

(VI) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood products furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with

congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.

(VII) ~~Materials for anesthesia.~~—These include the anesthetic and any materials necessary for its administration.

(ii) ~~Services not included in facility reimbursement rates.~~ The following services are not included in the facility reimbursement rate:

(I) ~~Physicians' services.~~ This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/post-operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually includes in a set "global" fee for a given surgical procedure.

(II) ~~The sale, lease, or rental of durable medical equipment to facility patients for use in their homes.~~ If the facility furnishes items of DME to patients it should be treated as a DME supplier and these services billed on a separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.

(III) ~~Prosthetic devices.~~ Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prosthesis is intra-ocular lenses (IOL's). Prosthetic devices should be billed as a separate line item using appropriate HCPCS code.

(IV) ~~Ambulance services.~~ If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs.

(V) ~~Leg, arm, back and neck braces.~~ These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.

(VI) ~~Artificial legs, arms, and eyes.~~ This equipment is not considered part of the facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.

(VII) ~~Services of an independent laboratory.~~ Payment for laboratory services is limited to the scope of the Authority's Medical Programs.

(iii) ~~Reimbursement—facility services.~~ The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, reimbursement will be made for only the major procedure. Reimbursement will be made at a state-wide payment rate based on Medicare's established groups.

(iv) ~~Compensable procedures.~~ The HCPCS codes identify the compensable procedures and should be used in billing.

(O) ~~Outpatient hospital services for persons infected with tuberculosis (TB).~~ Outpatient hospital services are covered for persons infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays. Services to persons infected with TB are not limited to the scope of the Medicaid program; however, prior authorization is required for services that exceed the scope of coverage under Medicaid. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy".

(P) ~~Mammograms.~~ Medicaid covers one screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms.

(Q) ~~Treatment/Observation.~~ Payment is made for the use of a treatment room, or for the room charge associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Payment is not made for treatment/observation on the same day as an emergency room visit. Observation services are limited to one 24-hour period per incident. Observation services are not covered in addition to an outpatient surgery.

(R) ~~Clinic charges.~~ Payment is made for a facility charge for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner, physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.

(3) ~~Exclusions.~~ The following are excluded from coverage:

(A) ~~Inpatient diagnostic studies that could be performed on an outpatient basis.~~

(B) ~~Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.~~

(C) ~~Reversal of sterilization procedures for the purposes of conception are not covered.~~

(D) ~~Medical services considered to be experimental.~~

(E) ~~Services or any expense incurred for cosmetic surgery including removal of benign skin lesions.~~

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- (F) Refractions and visual aids.
- (G) Payment for the treatment of obesity.
- (H) Charges incurred while patient is in a skilled nursing or swing bed.

(b) **Inpatient status.** OHCA considers a member an inpatient when the member is admitted to the hospital and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

(1) **Same day admission.** If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

(2) **Same day admission/discharge C obstetrical and newborn stays.** A hospital stay is considered inpatient stay when a member is admitted and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This rule applies when the mother and/or newborn are transferred to another hospital.

(3) **Discharges and Transfers.**

(A) **Discharges.** A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

- (i) The patient is formally released from the hospital; or
- (ii) The patient dies in the hospital; or
- (iii) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred to a distinct part psychiatric or rehabilitation unit of the same hospital. Such instances will result in two or more claims. Effective January 1, 2007, distinct part psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

(B) **Transfers.**

(i) A discharge of a hospital inpatient is considered to be a transfer for purposes of payment if the discharge is made from a hospital included under the DRGBased payment system to the care of another hospital that is:

- (I) paid under the DRG-based payment system and in such instances the result will be that two (or more) claims will be generated; or
- (II) to a hospital excluded from the DRG-based payment system. Such instances will result in two or more claims.

(ii) Transfers from one inpatient area or unit of a DRG-based hospital to another inpatient area or unit of the same hospital will result in a single claim unless it is a distinct part unit as defined in (A)(iii).

(C) **Leaves of Absence.** OHCA considers a discharge as occurring when the member leaves the hospital for any reason other than a "leave of absence."

Normally a patient will leave a hospital only as a result of a discharge or transfer. However, there are some circumstances where a patient is admitted for care, and for some reason is sent home temporarily before that care is completed. Hospitals may place patients on leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples of such situations include, but are not limited to, situations where surgery could not be scheduled immediately, additional testing which is not available at that particular time, or a change in the patient's condition.

317:30-5-41.1. Acute inpatient psychiatric services

(a) Inpatient stays in a psychiatric unit of a general medical/surgical hospital are covered for members of any age. See OAC 317:30-5-95 for coverage in a freestanding psychiatric hospital or psychiatric residential treatment facility.

(b) **Utilization Control.** All psychiatric admissions must be prior authorized. SoonerCare utilization control requirements applicable to inpatient psychiatric services in freestanding psychiatric hospitals apply to acute care hospitals. Acute care hospitals are required to maintain the same level of documentation on individuals receiving psychiatric services as the freestanding psychiatric facilities (refer to OAC 317:30-5-95.12).

317:30-5-42. Coverage for children

Payment is made to hospitals for medical and surgical services for persons under the age of 21 within the scope of the Authority's Medical Programs, provided the services are reasonable for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services are comparable to those listed for adults except as follows.

(1) **Inpatient general acute care services limitations.** All medically necessary inpatient hospital services, other than psychiatric services, for all persons under the age of 21 will not be limited.

(2) **Utilization control requirements for psychiatric beds.** Medicaid utilization control requirements applicable to inpatient psychiatric services for persons under 21 years of age in psychiatric facilities apply to acute care hospitals. Acute care hospitals are required to maintain the same level of documentation on individuals receiving psychiatric services as the free standing psychiatric facilities (refer to OAC 317:30-5-95.2).

(3) **Outpatient hospital services.** Payment is made for outpatient hospital services, including lab and x-rays.

(4) **Outpatient physical therapy.** Payment is made for preauthorized outpatient physical therapy. Payment is limited to four visits per month.

(5) **Hospice Services.** Hospice is palliative and/or comfort care provided to the client and his/her family when a physician certifies that the client has a terminal illness and has six months or less to live and orders hospice care. A hospice program offers palliative and supportive care to meet the special needs arising out of

the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The hospice services must be related to the palliation and management of the client's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the patient and/or family has elected hospice benefits in lieu of standard Medicaid services that have the objective to treat or cure the client's illness. Once the client has elected hospice care, the hospice medical team assumes responsibility for the client's medical care for the terminal illness in the home environment. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the client and/or family. Services must be prior authorized. Hospice care is available for two 90 day periods and an unlimited number of 60 day periods during the remainder of the patient's lifetime. However, the patient and/or the family may voluntarily terminate hospice services. To be covered, hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the patient's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify or re certify the terminal illness. A plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

(6) **Exclusions.** The following are excluded from coverage:

- (A) Inpatient diagnostic studies that could be performed on an outpatient basis.
- (B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.
- (C) Sterilization of persons who are under 21 years of age.
- (D) Reversal of sterilization procedures for the purposes of conception.
- (E) Hysterectomy, unless therapeutic and unless a copy of an acknowledgment form, signed by the patient or an acknowledgment by the physician that the patient has already been rendered sterile is attached to the claim.
- (F) Medical services considered to be experimental.

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to OHCA contracted, non-hospital providers performing the same services.

Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient.

(4) The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).

317:30-5-42.2. Blood and blood fractions

Payment is made for blood and blood fractions and the administration of blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood and not available from another source.

317:30-5-42.3. Chemotherapy and radiation therapy

Payment is made for charges incurred for the administration of chemotherapy for the treatment of medically necessary and medically approved procedures. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

317:30-5-42.4. Clinic/treatment room services; urgent care

(a) An outpatient hospital clinic is a non-emergency service providing diagnostic, preventive, curative and rehabilitative services on a scheduled basis.

(b) Urgent care payment is made for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner, physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.

(c) Urgent Care services will not require a referral for SoonerCare Choice members however other claims will deny without a referral.

(d) Adults are limited to four clinic visits per month.

317:30-5-42.5. Diagnostic testing therapeutic services

(a) Reimbursement is made for diagnostic testing to diagnose a disease or medical condition.

(b) Separate payment may be made for ancillary services that are not covered as an integral part of a facility fee.

317:30-5-42.6. Dialysis

Payment for dialysis is made at the all-inclusive Medicare allowable composite rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure, such as routine medical supplies, certain laboratory

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procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen). The physician is reimbursed separately.

317:30-5-42.7. Emergency department (ED) care/services

Emergency department care must:

- (1) Be provided in a hospital with a designated emergency department; and
- (2) Provide direct patient care, including patient assessment, monitoring, and treatment by hospital medical personnel such as physicians, nurses, or lab and x-ray technicians.
 - (A) Medical records must document the emergency diagnosis and the extent of direct patient care.
 - (B) Emergency department care does not include unattended waiting time.
 - (C) Emergency services are covered for a medical emergency. This means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - (i) Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or continuation of severe pain;
 - (ii) serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death.
 - (D) Labor and delivery is a medical emergency, if it meets this definition.
- (3) Prescheduled services are not considered an emergency.
- (4) Services provided as follow-up to initial emergency care are not considered emergency services.

317:30-5-42.8. Hearing and speech therapy

Payment is covered for hearing and speech services, including evaluations, for children when prior authorized.

317:30-5-42.9. Infusions/injections

Intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions are covered when medically necessary and not considered a compensable part of the procedure.

317:30-5-42.10. Laboratory

Payment is made for all laboratory tests listed in the Clinical Diagnostic Laboratory fee schedule from CMS. To be eligible for payment as a laboratory/pathology service, the service must be:

- (1) Ordered and provided by or under the direction of a physician or other licensed practitioner within the scope of practice as defined by state law;

- (2) Provided in a hospital or independent laboratory;
- (3) Directly related to the diagnosis and treatment of a medical condition; and
- (4) Authorized under the laboratory's CLIA certification.

317:30-5-42.11. Observation/treatment

(a) Payment is made for the use of a treatment room associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Observation services must include a minimum of 8 hours of continuous care. Outpatient observation services are not covered when they are provided:

- (1) On the same day as an emergency department visit.
- (2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.
- (3) For the convenience of the member, member's family or provider.
- (4) When specific diagnoses are not present on the claim.

(b) Payment is made for observation services in a labor or delivery room. Specific pregnancy-related diagnoses are required. During active labor, a fetal non-stress test is covered in addition to the labor and delivery room charge.

317:30-5-42.12. Physical therapy

Payment is made for preauthorized outpatient physical therapy, including evaluations, for children.

317:30-5-42.13. Radiology

Payment is made for the technical component of outpatient radiation therapy and compensable x-ray procedures.

- (1) **Mammograms.** Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.
- (2) **Ultrasounds.** Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A)-(C).

317:30-5-42.14. Surgery

(a) **Reimbursement.** Reimbursement is made for selected surgeries performed in an outpatient hospital. When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.

(b) **Ambulatory Surgery Center Groups.** The Medicare definition of covered Ambulatory Surgery Center (ASC) facility services includes services furnished on a outpatient basis in connection with a covered surgical procedure. This is a bundled payment that includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used

by the patient or offered for use to patients scheduled for surgical procedures. It includes all services and procedures in connection with covered procedures provided by facility personnel and others involved in patient care. These services do not include physician services, or other health services for which payment can be made under other OHCA medical program provisions (e.g., services of an independent laboratory located on the same site as the ASC, prosthetic devices other than intra ocular lenses (IOLs), anesthetist services, DME). (See OAC 317:30-5-565 for items separately billable.)

(c) **Ambulatory Patient Classification (APC) Groups.** Certain surgical services filed with revenue code series 36X and 49X and that do not fall within an Ambulatory Patient Classification (ASC) group will pay a SoonerCare rate based on Medicare's APC groups. This is not a bundled rate. Other lines on the claim may pay.

(d) **Multiple Surgeries.** Multiple surgeries refers to more than one surgical procedure done on the same person on the same day. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries are paid at a lesser amount. When multiple ASCs or APCs are performed in the same operative session, payment will be the rate of the procedure in the highest payment group.

(e) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in the outpatient hospital unless medically necessary.

(f) **Dental Procedures.** Dental services are routinely rendered in the dental office, unless the situation requires that the dental service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or member. Dental procedures are not covered as Medicare ASC procedures. For OHCA payment purposes, the ASC list has been expanded to cover these services for children. Non-emergency routine dental that is provided in an outpatient hospital setting is covered only under the following circumstances for children or adults who are residents in ICFs/MR:

- (1) A concurrent hazardous medical condition exists;
- (2) The nature of the procedure requires hospitalization or;
- (3) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

(g) **Special Procedures.** Certain procedures rendered in a designated area of a licensed hospital dedicated to specific procedures (i.e. Cardiac Catheterization Lab, etc.) are covered and are not paid at a bundled rate. When multiple APC procedures are performed in the same visit, payment will be the rate of the procedure in the highest payment group.

317:30-5-42.15. Outpatient hospital services for members infected with tuberculosis

Outpatient hospital services are covered for members infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays.

- (1) Services to members infected with TB are not limited to the scope of the SoonerCare program; however,

prior authorization is required for services that exceed the scope of coverage under SoonerCare.

(2) Drugs prescribed for the treatment of TB not in accordance with OAC 317:30-3-46 require prior authorization by the OHCA Pharmacy Helpdesk using form "Petition for TB Related Therapy."

317:30-5-42.16. Related services

(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the Authority's Medical Programs.

(b) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the OHCA.

(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.

(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.

(3) Payment is made for standard medical supplies.

(4) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.

(5) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).

(6) Payment may be made to home health agencies for prosthetic devices.

(A) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate.

(B) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.

(C) Sterile tracheotomy trays are covered.

(D) Payment is made for colostomy and urostomy bags and accessories.

(E) Payment is made for hyperalimentation, including supplements, supplies and equipment rental in behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.

(F) Payment is made for ventilator equipment and supplies when prior authorized.

(G) Payment for medical supplies, oxygen, and equipment is made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(c) **Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and

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has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits in lieu of standard SoonerCare services that have the objective to treat or cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.

(2) Hospice care is available for two initial 90-day periods and an unlimited number of subsequent 60-day periods during the remainder of the member's lifetime. However, the member and/or the family may voluntarily terminate hospice services.

(3) Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness.

(4) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

(1) Inpatient diagnostic studies that could be performed on an outpatient basis.

(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.

(3) Reversal of sterilization procedures for the purposes of conception are not covered.

(4) Medical services considered to be experimental.

(5) Payment for removal of benign skin lesions unless medically necessary.

(6) Refractions and visual aids.

(7) Charges incurred while patient is in a skilled nursing or swing bed.

317:30-5-42.18. Coverage for children

(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered under the EPSDT/OHCA Child Health program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.

(b) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services rendered on or after October 1, 2005, in the following manner:

(1) Covered inpatient services provided to eligible Medicaid Recipients SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each Medicaid recipient's SoonerCare member's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay. In addition to the DRG payment, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if the DRG payment is less than a threshold amount \$50,000 of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage 70% of the cost after the \$50,000 threshold is met.

(2) The DRG payment and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) technical component on radiology services;

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) pre-admission diagnostic testing performed within 72 hours of admission; and

(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible Medicaid Recipients members of the Oklahoma Medicaid SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective

utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

~~(7) Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed under a retrospective utilization review policy to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.~~

~~(8) Hospital stays less than three days in length will be reviewed under a retrospective utilization review policy for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.~~

(9) Organ transplants must be performed at an institution approved by the OHCA for the type of transplant provided. The transplant must be reviewed for medical appropriateness.

~~(10) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare Medicaid recipients members and the provider will not accept the DRG payment rate. Prior authorization is required.~~

(11) New providers entering the Medicaid SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

~~(12) Payments will be made to hospitals qualifying for Disproportionate Hospital adjustments, and graduate medical education activities pursuant to the methodologies described in the Oklahoma Title XIX Inpatient Hospital Reimbursement Plan, effective date October 1, 2005, and incorporated herein by reference.~~

317:30-5-47.1. Reimbursement for newborn screening services provided by the OSDH

Reimbursement for inpatient hospital services is made based on a prospective per diem level of care payment system. The per diem includes all non-physician services furnished either directly or under arrangements. Newborn screening performed by the Oklahoma State Department of Health in accordance with State Law is excluded from the inpatient per diem DRG payment.

317:30-5-47.2. Disproportionate share hospitals (DSH)

(a) **Eligibility.** A hospital shall be deemed a disproportionate share hospital, as defined by Section 1923 of the federal Social Security Act, if the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or if the hospital's low-income utilization rate exceeds 25%.

~~(1) Eligibility for disproportionate share hospital payments will be determined annually by the OHCA before the beginning of each federal fiscal year based on cost and revenue survey data completed by the hospitals. The survey must be received by OHCA each year by April 30. The information used to complete the survey must be extracted from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year, for entities that meet the Medicare Provider designation (refer to Medicare Program Memorandum No. A-96-7 for requirements). A hospital may not include costs or revenues on the survey which are attributable to services rendered in a separately licensed/certified entity. Hospitals found to be ineligible for disproportionate share status upon audit shall be required to reimburse the Authority for any disproportionate share payment adjustments paid for the period of ineligibility.~~

(2) Beyond meeting either of the tests found in (1) of this subsection, there are three additional requirements which are:

~~(A) Any hospital offering non-emergency obstetrical services must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid beneficiaries. This requirement does not apply to children's hospitals.~~

~~(B) In the case of an urban hospital, a hospital located in a MSA, an obstetrician is defined as any board-certified obstetrician with staff privileges who performs non-emergency obstetrical services at the hospital. In the case of a rural hospital, an obstetrician is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital.~~

~~(C) A hospital must have a Medicaid inpatient utilization rate of at least one percent.~~

(b) **Payment adjustment.**

(1) Beginning federal fiscal year 1993 and each year thereafter, DSH payment adjustments will be capped by the federal government. Financial participation from the federal government will not be allowed for expenditures exceeding the capped amount. Eligible DSH hospitals will be assigned to one of the three following categories:

~~(A) public private acute care teaching hospital which has 150 or more full-time equivalent residents enrolled in approved teaching programs (using the most recently of Oklahoma. Public private hospital is a former state operated hospital that has entered into a joint operating agreement with a private hospital system;~~

~~(B) other state hospitals; or~~

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- (C) private hospitals and all out of state hospitals.
- (2) Payment adjustments will be made on a quarterly basis for federal fiscal year 1994 and thereafter using the following formula that determines the hospital's annual allocation:
- (A) Step 1.—The Medicaid revenue and imputed revenue for charity are totaled for each hospital qualifying for disproportionate share adjustments.
- (B) Step 2.—A weight is assigned to each qualifying hospital by dividing each hospital's revenue total (Medicaid and charity) by the revenue total of the public/private acute care teaching hospital, which has the assigned weight of 1.0.
- (C) Step 3.—A weighted value is then determined for each hospital by multiplying the hospital's assigned weight by the hospital's total Medicaid and charity revenue.
- (D) Step 4.—The weighted values of all hospitals qualifying for disproportionate share adjustments are totaled.
- (E) Step 5.—The percentage of the public-private acute care teaching hospital's weighted value is determined in relation to the weighted values of all qualifying disproportionate share hospitals.
- (F) Step 6.—The weighted values of all state hospitals (except public-private acute care teaching hospital) are totaled.
- (G) Step 7.—The weighted values of all private and out of state hospitals qualifying for disproportionate share adjustments are totaled.
- (H) Step 8.—The percentage of the total weighted values of the hospitals included in Step 6 (State hospitals except public-private acute care teaching hospital) is calculated in relation to the total weighted values (sum of Step 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.
- (I) Step 9.—The percentage of weighted values of the hospitals included in Step 7 (private hospitals and all out of state hospitals) is calculated in relation to the total weighted values (sum of Steps 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.
- (J) Step 10.—The weighted percentages for the three hospital groups are next applied to the capped disproportionate share amount allowed by CMS for the federal fiscal year. The amount of disproportionate share to be paid to the public-private acute care teaching hospital is determined by multiplying the state disproportionate share allotment by the weighted percentage of the public-private acute care teaching hospital. Beginning FFY 96, the weighted percentage amount to be paid will not exceed 82.82%. Payment of disproportionate share funds to public/private hospitals will be made to the public entity that is organizationally responsible for indigent care. The weighted percentage amount is then subtracted from the state disproportionate share allotment. Once the public-private acute care

teaching hospital's share of the state disproportionate share allotment has been subtracted, the state hospitals' weighted percentage is applied to the remainder. Beginning FFY 96, the State hospital's weighted percentage [from (H) of this paragraph] will not be less than 75.3%. The balance of the disproportionate share allotment is distributed to private hospitals and all out of state hospitals. Distribution of funds within each group will be made according to the relationship of each hospital's weighted value to the total weighted value of the group. (3) Payment adjustments to individual hospitals will be limited to 100 percent of the hospital's costs of providing services (inpatient and outpatient) to Medicaid recipients and the uninsured, net of payments received from Medicaid (other than DSH) and uninsured patients. Payment will be made to hospitals qualifying for Disproportionate Share Hospital adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.

317:30-5-47.3. Indirect medical education (IME) adjustment

- (a) Effective February 11, 1999, acute care hospitals that qualify as major teaching hospitals will receive an indirect medical education (IME) payment adjustment, which covers the increased operating, or patient care, costs that are associated with approved intern and resident programs.
- (b) In order to qualify as a major teaching hospital and be deemed eligible for an IME adjustment, the hospital or hospitals of common ownership must:
- (1) belong to the Council on Teaching Hospitals or have a medical school affiliation; and
 - (2) be licensed by the State of Oklahoma; and
 - (3) have 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.
- (c) Eligibility for an IME adjustment will be determined by the OHCA, using the provider's most recently received annual cost report or the application (see OAC 317:30-5-47.3) for the quarterly Direct Medical Education Supplemental payment adjustment.
- (d) An annual fixed IME payment pool will be established based on the State matching funds made available by transfers from other State agencies. The pool of funds will be distributed annually each State fiscal year. The total pool of monies made available by funds transferred by any State agency will be limited to \$10,038,714, the 1999 base year amount. The base year payment amount will be updated annually each July 1 using the first quarter publication of the DRI PPS-type Hospital market basket forecast for the midpoint of the upcoming fiscal year, if funds are available.
- (e) The payments will be distributed equally. For hospitals that have public-private ownership, or have entered into a joint operating agreement, payment will be made to the public entity that is organizationally responsible for the public teaching mission.

(f) If payment causes total payments to exceed Medicare upper limits as required by 42 CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.

Payment will be made to hospitals qualifying for Indirect Medical Education payment adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.

317:30-5-47.4. Direct medical education supplemental incentive payment adjustment

(a) Effective July 1, 1999, in-state hospitals that qualify as teaching hospitals will receive a supplemental payment adjustment for direct medical education (DME) expenses. These payments will be made in order to encourage training in rural hospital and primary care settings and to recognize the loss of support for GME due to the advent of Managed Care capitated programs.

(b) In order to qualify as a teaching hospital and be deemed eligible for DME supplemental incentive payment adjustments, the hospital must:

- (1) be licensed by the State of Oklahoma;
- (2) have costs associated with approved or certified Oklahoma medical residency programs in medicine, osteopathic medicine, and associated specialties and sub specialties. An approved medical residency program is one approved by the Accrediting Council for Graduate Medical Education of the American Medical Association, by the Bureau of Professional Education of the American Osteopathic Association, or other professional accrediting associations. A resident is defined as a Post Graduate Year 1 (PGY1) and above resident who participates through hospital or hospital based rotations in approved medical residency/internship programs in Family Medicine, Internal Medicine, Pediatrics, Surgery, Ophthalmology, Psychiatry, Obstetrics/Gynecology, Anesthesiology, Osteopathic medicine, or other Certified Medical Residencies, including specialties and sub specialties as required in order to become certified by the appropriate board; and
- (3) apply for certification by the OHCA prior to receiving payments for any quarter during a State Fiscal year. To qualify, a hospital must have a contract with the Oklahoma Health Care Authority (OHCA) to provide Medicaid services and belong to The Council on Teaching Hospitals or otherwise show proof of affiliation with an approved Medical Education Program. Affiliation means an agreement to support the costs of medical residency education in the approved programs.

(4) Federal and state hospitals, including Veteran's Administration, Indian Health Service/Tribal and Oklahoma Department of Mental Health and Substance Abuse Services Hospitals are not eligible for supplemental DME payments. Major teaching hospitals are eligible.

(c) Determination of a hospital's eligibility for a DME supplemental payment adjustment will be done quarterly by the OHCA based on reports designed by the OHCA. The reports

will detail the resident months of support provided by the hospital and the total eligible Medicaid days of service from the paid claims for the same quarter and be attested to by the hospital Administrator, or designated personnel. The annual application must be attested to by the hospital administrator and by the residency program director. All reports will be subject to audit and payments will be recouped for inaccurate or false data. The amount of resident months will also be compared to the annual budgets of the schools, the annual CMS form 2552 (Cost Report) and the monthly assignment schedules.

(d) An annual fixed DME payment pool will be established based on the State Matching funds made available by the University Hospitals Authority or other State agencies.

(e) The payments will be distributed based on the relative value of the weighted resident months at each participating hospital. A resident month is defined as a PGY1 and above resident fulltime equivalent (FTE) for that month. Resident is defined in (b)(2) of this section. An FTE is defined as a resident assigned by the residency program to a rotation that is hospital or hospital based. The resident must be assigned to a specific hospital for a supervised hospital based residency experience. Required residency clinical or educational experience will be allowed. The time residents spend in non-provider settings such as freestanding clinics, nursing homes and physicians' offices in connection with approved programs may be included in determining the number of FTE's in the count if the following conditions are met:

- (1) The resident spends his or her time in patient care activities.
- (2) The written agreement between the hospital and the non hospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the non hospital site and the hospital is providing reasonable compensation to the non hospital site for supervisory teaching activities.
- (3) The hospital must incur all or substantially all of the costs for the training program in the non hospital setting, which means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

(f) Training outside the formal residency program (moonlighting) is not eligible for this payment. The pool of available funds will be distributed quarterly based on the relative value of the eligible hospitals' resident months weighted for Medicaid services rendered.

- (1) The weighted relative value is determined as follows:
 - (A) Annually (prior to each state fiscal year) the OHCA will determine each participating hospital's individual acuity factor from data taken from the Oklahoma MMIS system (or reported claims data) by using the days of services and weights determined for the levels of care.
 - (B) Determine the total resident months from the quarterly reports in (c) of this section for each hospital.

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(C) Determine the total eligible patient days for the quarter from the quarterly reports in (c) of this section for each hospital reporting.

(D) Determine the relative value for each hospital. The relative value is defined as the product of the individual acuity factor [see (A) of this paragraph] times the total resident months [see (B) of this paragraph] times the eligible patient days [see (C) of this paragraph].

(2) The pool of available funds will be allocated quarterly based on the prior quarter's relative value as determined in (1)(D) of this subsection. The per resident month amount will be limited to \$11,000 and the total payments will be limited to and not exceed the upper payment limits described in (g) of this section.

(g) If payment in (d) of this section causes total payments to exceed Medicare upper limits as required by CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit. Payment will be made to hospitals qualifying for Direct Medical Education payment adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.

317:30-5-50. Abortions

(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. ~~Medicaid—SoonerCare~~ coverage for abortions to terminate pregnancies that are the result of rape ~~or or incest will only be or incest~~ are considered to be medically necessary services and federal financial participation is available specifically for these services.

(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.

(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the patient must fully complete the Patient Certification For Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological

reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. In cases where a physician provides certification and documentation of a client's inability to file a report, the Authority will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.

(b) The Oklahoma Health Care Authority performs a look-behind procedure for abortion claims paid from Medicaid SoonerCare funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under Medicaid SoonerCare. On a post payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.

(c) Claims for spontaneous abortions, including Dilation and Curettage do not require certification. The following situations also do not require certification:

- (1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion, and
- (2) If the process has irreversibly commenced at the point of the physician's medical intervention.

(d) Claims for the diagnosis incomplete abortion require medical review. The appropriate diagnosis codes should be used indicating spontaneous abortion, etc.; otherwise the procedure will be denied.

317:30-5-56. Utilization review

All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment. In addition to the random sample of all admissions, retrospective review policy includes the following:

(1) Hospital stays less than three days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(2) Cases which indicate transfer from one acute care hospital to another will be monitored to help ensure that payment is not made for inappropriate transfers.

(3) Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

317:30-5-57. Notice of denial

(a) **General.** It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a SoonerCare member. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days.

(b) **Reconsideration request.** All inpatient stays and outpatient observation services are subject to post-payment utilization review by the OHCA's designated Quality Improvement Organization (QIO). These reviews are based on severity of illness and intensity of treatment. It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay or outpatient observation of a SoonerCare member. If the QIO, upon their initial review determines the admission or outpatient observation services should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified time frame on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

(c) **Reconsideration request not made.** If the hospital or attending physician did not request reconsideration from the QIO, the QIO informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(d) **Patient liability.** If an OHCA, or its designated agent, review results of a denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the member cannot be billed for the denied services.

(1) If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not compensable but the member insists on treatment, the member should be informed in writing that he/she will be personally responsible for all charges.

(2) If a claim is filed and paid and the service is later denied the member is not responsible.

PART 63. AMBULATORY SURGICAL CENTERS

317:30-5-566. Outpatient surgery services

The covered facility services are defined as those services furnished by an ASC or OHF in connection with a covered surgical procedure.

(1) **Services included.** Services included in the facility reimbursement rate are:

(A) Nursing, technicians, and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.

(B) Use by the patient member of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

(C) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures, including any drugs and biologicals administered while the patient member is in the facility. Surgical dressings, other supplies, splints, and casts include only those furnished by the facility at the time of surgery. Additional supplies and materials furnished later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the patient member and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

(D) Diagnostic or therapeutic items and services directly related to the surgical procedures. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.

(E) Administrative, recordkeeping and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.

(F) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood fractions furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.

(G) Materials for anesthesia. These include the anesthetic and any materials necessary for its administration.

(2) **Services not included in facility reimbursement rates are:**

(A) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/post-operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually

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includes in a set global fee for a given surgical procedure.

(B) The sale, lease or rental of durable medical equipment (DME) to ~~patients~~ members for use in their homes. If the facility furnishes items of DME to ~~patients~~ members it should be treated as a DME supplier and this requires a separate contract and separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.

(C) Prosthetic devices. Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prostheses is ~~intraocular~~ intra ocular lenses (IOL's). These should be billed as a separate line item.

(D) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs. This requires a separate contract and a separate claim form.

(E) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.

(F) Artificial legs, arms and eyes. This equipment is not considered part of a facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.

(G) Services of an independent laboratory. Payment for laboratory services is limited to the scope of the Authority's Medical Programs.

(H) Reimbursement - facility services. The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, reimbursement will be made for only the major procedure. Reimbursement will be made at a state-wide payment rate based on ~~Medicare's~~ Medicare's established groups as adapted for ~~Medicaid~~ SoonerCare.

(3) **Compensable procedures.** The List of Covered Surgical Procedures in (1) of this Section sets out those procedures for which the Authority will recognize a facility charge if otherwise compensable under the Authority's Medical Programs. If a procedure code is not on the list the Authority will not pay a facility charge.

(A) The inclusion of a procedure on this list does not in any way change any of the overall coverage limitations or exclusions of the ~~Medicaid~~ SoonerCare program. For instance, the program generally excludes coverage for cosmetic surgery, ~~surgery for obesity~~, and sexual reassignment. This list sets out the coverage and payment provisions if the procedure is otherwise compensable.

(B) The procedures are listed by body system, HCPCS codes, a brief description of the procedure and the applicable group payment rate.

(C) The HCPCS codes further identify the compensable procedures and should be used in billing.

317:30-5-567. Coverage by category

Payment is made for ambulatory surgical center services as set forth in this Section.

(1) **Children.** Payment is made for children for medically necessary surgical procedures which are included on the List of Covered Surgical Procedures.

(A) Services, deemed medically necessary and allowable under federal regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(B) Federal regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

(2) **Adults.** Payment is made for adults for medically necessary surgical procedures which are included on the List of Covered Surgical Procedures.

(3) **Individuals eligible For Part B of Medicare.** Payment is made utilizing the ~~Medicaid~~-OHCA allowable for comparable services.

[OAR Docket #07-713; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-712]

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PERMANENT final adoption

RULES:

Subchapter 5. Individual Providers and Specialities

Part 33. Transportation by Ambulance

317:30-5-335 [AMENDED]

317:30-5-335.1 [NEW]

317:30-5-336 [AMENDED]

317:30-5-336.1 through 317:30-5-336.13 [NEW]

317:30-5-337 [AMENDED]

317:30-5-339 [AMENDED]

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Part 33. Transportation by Ambulance

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317:30-5-335.1 [NEW]

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ANALYSIS:

Transportation rules are revised to establish a payment and billing method for contracted air ambulance providers that transport SoonerCare members out-of-state from the airport to the admitting hospital. Currently, if a member has to be transported by air ambulance, the air ambulance provider bills the agency via an invoice for expenses incurred for ground transportation. Current CPT codes provide for out-of-state ground transportation. The change would enable the air-provider to sub-contract with out-of-state non-contracted ground ambulance providers and bill appropriate CPT codes for such service through the MMIS system. This type of transportation is provided only when medically necessary treatment can not be performed by an in-state provider. Revisions also address non-emergency stretcher services and the required criteria to be eligible for stretcher services. These revisions provide written criteria for current practices.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALITIES

PART 33. TRANSPORTATION BY AMBULANCE

317:30-5-335. Eligible providers

To be eligible for reimbursement, ~~an~~ all ambulance company service suppliers that operate air, water or ground services or a (including stretcher service) must be licensed by the State Department of Health (OSDH) consistent with the level of care they provide, in accordance with the Oklahoma Emergency Response System Development Act of 2005.

63 OS 1-2503. Ambulance suppliers that do not provide services in Oklahoma must be licensed by the appropriate agency in the state in which they provide services. Ambulance companies and all other transportation providers must have a current contract on file with the Oklahoma Health Care Authority (OHCA). Air Ambulance providers must indicate on the application for enrollment that they are requesting fixed wing or rotary wing ambulance status and provide a copy of their license with their enrollment application.

317:30-5-335.1. Definitions

The following words and terms, when used in this subchapter shall have the following meaning, unless the context clearly indicates otherwise.

"Ambulance" means a motor vehicle, watercraft, or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support.

"Bed confined" means that the member is unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair. The term bed confined is not synonymous with bed rest or non-ambulatory.

"Continuous or round trip" means an ambulance service in which the member is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the member is then transported to a more appropriate facility for care or back to the place of origin.

"Emergency transfer" means the movement of an acutely ill or injured member from the scene to a health care facility (pre-hospital), or the movement of an acutely ill or injured member from one health care facility to another health care facility (inter-facility).

"Loaded mileage" means the number of miles for which the member is transported in the ambulance.

"Locality" means the service area surrounding the facility from which individuals normally travel or are expected to travel to seek medical care.

"Medically necessary transport" means an ambulance transport that is required because no other effective and less costly mode of transportation can be used due to the member's medical condition. The transport is required to transfer the member to and/or from a medically necessary service not available at the primary location.

"Nearest appropriate facility" means that the receiving institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician specialist is available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a member of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

"Non-emergency transfer" means the movement of any member in an ambulance other than an emergency transfer.

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"Stretcher service" means a non-emergency transport by a ground vehicle that is approved by the OSDH which is designed and equipped to transport individuals on a stretcher or gurney type apparatus that is operated to accommodate an incapacitated or disabled person who does not require medical monitoring, aid, care or treatment during transport.

317:30-5-336. General coverage Coverage for adults

Ambulance transportation for adults is covered as set forth in this Section. OHCA covers ground and air ambulance transportation services, within certain limitations.

(1) Covered services.

(A) ~~Ambulance and stretcher transportation is covered only when medically necessary and when due to the patient's member's condition any other method of transportation is contraindicated. Stretcher service is limited to those situations within the scope of the license extended to the entity. The OHCA's Non-Emergency Transportation (NET) Waiver, known as SoonerRide, is the first choice for non-emergency transportation for scheduled medical services. SoonerRide provides non-emergency transportation in accordance with all applicable criteria set forth in the American's with Disabilities Act (ADA). Regularly scheduled non-emergency medical services, such as outpatient dialysis, must be scheduled through SoonerRide unless the patient's condition requires transportation by stretcher or ambulance. All claims for scheduled trips for outpatient services which cannot be provided by SoonerRide must be accompanied by medical documentation to substantiate the need for the higher level of transportation and will be reviewed prior to payment by OHCA staff. Ambulance or stretcher transport for unscheduled emergent medical care will be covered if the trip meets all applicable criteria.~~

(B) ~~As a general rule, only ambulance or stretcher transportation within the ambulance locality is covered. Ambulance locality means the service area surrounding the facility from which individuals normally travel or are expected to travel to seek medical care. OHCA utilizes the locality areas as defined by Medicare. If ambulance transportation is provided out of the ambulance locality, the claim must be documented with the reason for the trip outside of the service area. If it is determined the patient was transported out of locality and the closest facility could have cared for the patient, payment will be made only for the distance to the nearest medical institution with appropriate facilities.~~

(C) ~~Appropriate facilities means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician specialist is available to provide the necessary care required to treat the patient's~~

~~condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.~~

(D) ~~The fact that a more distant institution is better equipped to care for the patient does not mean that a closer institution does not have "appropriate facilities". Such a finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. However, a legal impediment barring a patient's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of non-residents.~~

(E) ~~An institution is also not considered an appropriate facility if no bed is available. However, the medical records must be properly documented.~~

(F) ~~Transportation to the outpatient facilities of a hospital, free standing Ambulatory Surgery Center, Independent Diagnostic Testing Facility (IDTF), physician's office, or other outpatient facility is compensable if the patient's condition necessitates ambulance transportation. See definition of bed confined in (P) of this paragraph.~~

(G) ~~If a beneficiary is transported to a destination and returned to their original point of pickup, coverage will include payment for the primary transport and return transport. If the provider is required to remain and attend the patient between transports, the provider may claim waiting time. Waiting time shall be paid in half hour increments and shall not include the first half hour. The first 30 minutes of waiting time is included in the base rates.~~

(H) ~~Ambulance transportation from a hospital with a higher level of care to a hospital in the locality is covered.~~

(I) ~~Transportation from a hospital to a hospital with a lower level of care is covered only if the patient is expected to be inpatient for a period greater than one week and the transfer will afford the patient greater access to family and/or caregivers.~~

(J) ~~Ambulance transportation from nursing home to nursing home (skilled or intermediate care) is covered only if the discharging institution is not certified and the admitting nursing home is certified. Nursing home to nursing home transfers are also covered if the patient requires care not available at the discharging facility, i.e., secure Alzheimer's Unit, and the patient's medical status requires ambulance transport.~~

(K) Transportation for residents of nursing facilities to hospital and back home on same day is covered if medical necessity is documented.

(L) Ambulance transportation to a Veteran's Administration Hospital is covered when the trip has not been authorized by the VA.

(M) If the patient refuses treatment after immediate aid has been provided, the ambulance may bill for waiting time and the base rate.

(N) When twins are transported, payment is made for only one trip as twins are considered as one passenger.

(O) Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished, not simply on the vehicle used.

(P) Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. Non-emergency transports are not covered unless the patient is bed confined or has a medical condition that requires medical expertise not available with a less specialized method of transportation. Bed confined means that the patient is unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair. The term bed confined is not synonymous with bed rest or non-ambulatory.

(Q) If the patient dies before dispatch, no payment is available. If the patient dies after dispatch, but before the patient is loaded, payment is allowed for the base rate but no mileage. If the patient dies after pickup, payment is available for the base rate and mileage. Time of death is the point at which the patient is pronounced dead by an individual authorized by the State to make such pronouncements.

(R) Air Ambulance Services, which includes fixed and rotary wing transportation, are covered only where:

(i) The point of pickup is inaccessible by land vehicle; or

(ii) Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities and speedy admission is essential; i.e., in cases where transportation by land ambulance is contraindicated; and

(iii) Instances where the patient's condition and other circumstances of the case necessitated the use of this type of transportation. However, where land ambulance service would have sufficed, payment should be based on the amount payable for land ambulance, if this is less costly.

(iv) Base rate includes the lift off, professional intensive care, transport isolette, ventilator setup, respiratory setup, and all other medical services provided during the flight.

(v) If the accident scene is inaccessible by air and a land ambulance must pick up the patient to

transport to a site where the air ambulance can land, the land ambulance trip is covered.

(vi) Air transportation is covered only to a hospital.

(vii) If the patient dies before takeoff, no payment is made. This includes situations in which the air ambulance has taxied to the runway, has been cleared for takeoff, but has not actually taken off. Failure of the dispatcher to notify the pilot of the death does not negate this rule. If the patient dies after takeoff but before the patient is loaded, payment is made for the base rate but no mileage. If the patient dies after the patient is loaded, payment is made for the base rate and mileage. Time of death is defined as the point at which the patient has been pronounced dead by an individual authorized by the State to make such pronouncements.

(viii) Only one base rate is allowed per trip.

(2) Non-covered services. As a general rule ambulance transportation to the nearest appropriate facility in the locality is covered. OHCA utilizes the locality areas as defined by Medicare.

(A) Transportation by ambulance when patient's condition did not require that level of transportation and another mode of transportation would suffice.

(B) Ambulance transportation from residence to residence is not covered except for transfers from nursing home to nursing home when the transferring facility is not certified.

(C) Payment will not be made for ambulance transportation determined not to be medically necessary.

(D) Transportation to a funeral home, mortuary, or morgue is not covered.

(E) Ambulance transportation is not covered when provided while the patient was an inpatient. For example, transportation to and from another facility for tests, x rays, etc., while still an inpatient of another facility is not compensable. All non-physician services furnished an inpatient are part of the inpatient bill.

(F) Payment is not made for more than one base rate per trip.

(b) OHCA recognizes different levels of ambulance medical services by qualified ambulance staff according to the standards established by law and regulation through the Oklahoma Emergency Response System Development Act of 2005, '63 OS 1-2503.

(c) Ambulance medical services are divided into different levels for payment purposes. Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished, not simply on the vehicle used.

(d) Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the member's file.

(e) Clinical decisions can be made without delay if documentation to support coverage and medical necessity is submitted as part of the initial claim form. This may be accomplished

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by submitting supporting detailed documentation regarding the member's condition and need for ambulance/stretchers transport.

317:30-5-336.1. Medical necessity

(a) The member's condition must require the ambulance/stretchers transportation itself and the level of service provided, in order for the billed service to be considered medically necessary. Medical necessity is established when the member's condition is such that the use of any other method of transportation is contraindicated.

(b) The medical personnel in attendance, including the Emergency Medical Technician (EMT) at the scene of an emergency, determine medical necessity and appropriateness of service within the scope of accepted medical practice and SoonerCare guidelines.

(c) Non-emergency transports are not covered unless the member is bed confined or has a medical condition that requires medical expertise not available with a less specialized method of transportation. Medical necessity for non-emergency transports must be substantiated with a physician's written order.

317:30-5-336.2. Nearest appropriate facility

(a) OHCA covers transportation to the nearest facility that can appropriately treat the member.

(b) An institution is not considered an appropriate facility if the member's condition requires a higher level of care or specialized services available at the more distant hospital. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

(c) An institution is not considered an appropriate facility if no bed is available. However, the medical records must be properly documented.

317:30-5-336.3. Destination

(a) Transportation is covered from the point of origin to the Hospital, Critical Access Hospital or Nursing Facility that is capable of providing the required level and type of care for the member.

(b) Ambulance transportation from a hospital with a higher level of care to a hospital with a lower level of care in the locality is covered, provided all other criteria are met and approved by the OHCA.

(c) Non-emergency transportation to the outpatient facilities of a Hospital, free-standing Ambulatory Surgery Center (ASC), Independent Diagnostic Testing Facility (IDTF), Physician's office or other outpatient facility is compensable if the member's condition necessitates ambulance or stretchers transportation and all other conditions are met.

(d) Ambulance Transportation to a Veteran's Administration (VA) Hospital is covered when the trip has not been authorized by the VA.

317:30-5-336.4. Transport outside of locality

(a) If ambulance transportation is provided out of the transport locality, the claim must be documented with the reason for the transport outside of the service area.

(b) If it is determined the member was transported out of locality and the closest facility could have cared for the member, payment will be made only for the distance to the nearest medical institution with the appropriate facilities.

317:30-5-336.5. Levels of ambulance service, ambulance fee schedule and base rate

(a) In accordance with the Oklahoma Emergency Response System Development Act of 2005, '63 OS 1-2503, a license may be issued for basic life support, intermediate life support, paramedic life support, specialized mobile intensive care units, or stretchers aid vans.

(b) Effective October 1, 2005, the OHCA adopted the Medicare Ambulance Fee Schedule (AFS).

(1) The ambulance provider bills one base rate procedure. Levels of service base rates are defined at 42 CFR 414.605.

(2) The base rate must reflect the level of service rendered, not the type of vehicle in which the member was transported, except in those localities where local ordinance requires Advanced Life Support (ALS) as the minimum standard of service.

317:30-5-336.6. Mileage

(a) Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a member to his/her arrival at the destination.

(b) Coverage is allowed only to the nearest appropriate facility.

317:30-5-336.7. Waiting time

(a) Waiting time is reimbursable after the first 30 minutes when a physician deems it medically necessary for the ambulance provider to wait at a hospital while the member is being stabilized, with the intent of continuing the member's transport to an appropriate hospital for care or back to the point of origin.

(b) The maximum number of hours allowed for waiting time is four hours.

317:30-5-336.8. Special situations

(a) Continuous or round trip transport.

(1) If a member is transported to a destination and returned to their original point of pickup, coverage includes payment for the primary transport and the return transport.

(2) If the provider is required to remain and attend the member between transports, the provider may claim waiting time.

(b) Nursing facility.

(1) Ambulance or stretchers transportation from nursing home to nursing home (skilled or intermediate care) is

covered if the discharging institution is not certified and the admitting nursing home is certified.

(2) Nursing home to nursing home transports are covered if the member requires care not available at the discharging facility, and the member's medical status requires ambulance transport.

(c) **Multiple members per transport.**

(1) When more than one eligible member is transported at the same time, the only acceptable duplication of charges is half the base rate.

(2) Separate claims must be submitted for each member.

(3) No mileage or waiting time is to be charged for additional members. These services are included in the reimbursement of the first claim.

(d) **Multiple transports per member.** More than one transport per member on the same date of service is covered when the member received a different level of service on each transport (e.g., Advanced Life Support 1 and Basic Life Support). When more than one transport with the same level of care occurs on the same day medical necessity must be documented.

(e) **Multiple arrivals.** When multiple units respond to a call for services, only the entity that actually provides services for the member may bill and be paid for the services by the OHCA. The entity that rendered service/care bills for all services furnished.

(f) **No transport.** If member refuses treatment after immediate aid has been provided the ambulance may bill the base rate for the level of service and waiting time.

(g) **Pronouncement of death.**

(1) If the member dies before dispatch, no payment is available.

(2) If the member dies after dispatch, but before the member is loaded, payment is allowed for the base rate but no mileage.

(3) If the member dies after pickup, payment is available for the base rate and mileage.

(4) Time of death is the point at which the member is pronounced dead by an individual authorized by the state to make such pronouncements.

(h) **Out of state transports.**

(1) Out of state, non-emergency transports require prior authorization.

(2) The ambulance provider, home health agency, hospital, nursing facility, physician, case manager or social worker may request this authorization. The ambulance provider must retain the physician's order of medical necessity in the member's file to support the need for ambulance transportation.

(3) When a member is transported by ground ambulance to or from an air ambulance for out-of-state services, the ground and air ambulance providers providing the transports must bill OHCA independently. When the OHCA is unable to contract for the out-of-state ground transport, the ground and air ambulance charges (air service, medical team, ground transportation) may be consolidated and billed when the following conditions apply.

(A) The air ambulance provider furnishing air transportation (hereafter referred to as "the entity") arranges for ground transportation services and has a contract on file with the OHCA to subcontract for ground ambulance;

(B) The contract includes the requirement that the entity certifies that the ground transportation provider meets the minimum state licensure requirements in the state in which the service is provided;

(C) The entity certifies that the payment will be made to the ground provider;

(i) **Neonatal transports.**

(1) Coverage of neonatal transport includes neonatal base rate, loaded mileage, transfer isolette, and waiting time.

(2) The intensive care transport of critically ill neonate(s) (i.e. newborns to approved, designated neonatal intensive care units) is a covered service.

(3) When a trained hospital medical team from the receiving or transferring hospital accompanies a newborn on the transport ambulance services, the primary care of the newborn is the hospital team's responsibility, reimbursement for the hospital team is made to the hospital as part of the hospital rate.

317:30-5-336.9. Air ambulance

(a) Air Ambulance service, which includes fixed and rotary wing transportation, are covered only when:

(1) The point of pickup is inaccessible by land vehicle;
or,

(2) Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities and timely admission is essential; i.e., in cases where transportation by land ambulance is contraindicated; or

(3) The member's medical condition and other circumstances of the case necessitated the use of this type of transportation. However, where land ambulance service would have sufficed, payment is based on the amount payable for land ambulance, if this is less costly.

(b) Only one base rate is allowed per trip. Base rate includes the lift off, professional intensive care, transport isolate, ventilator setup, respiratory setup, and all other medical services provided during the flight. No additional payment is made to the air service provider for bedside to bedside service.

(c) If the accident scene is inaccessible by air and a land ambulance must pick up the member to transport to a site where the air ambulance can land, the land ambulance trip is covered. Air transportation is covered only to a hospital in this situation.

317:30-5-336.10. Fixed wing air ambulance services

(a) Fixed wing air ambulance transports must be prior authorized.

(b) Ambulance transport in a fixed wing aircraft is a covered service if the following requirements are met:

(1) The transport, including ancillary services (e.g. flight nurse), is ordered by a physician.

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- (2) The written physician order is maintained in the members file.
- (3) Transport by ground vehicle would endanger the member's life due to time and distance from the hospital.
- (4) Medically necessary care or services for the member's medical condition cannot be provided by a local facility.

317:30-5-336.11. Rotary wing air ambulance

Rotary wing air ambulance services are covered by the OHCA only under the following circumstances:

- (1) Time and distance in a ground ambulance would be a hazard to the life of the member;
- (2) The medically necessary care and services for the member's need are not available at the local hospital, and;
- (3) The transfer is for medical or surgical procedures, not solely for diagnostic services only.

317:30-5-336.12. Non-emergency ambulance and stretcher service transportation

(a) OHCA covers non-emergency ground, stretcher and air transportation to and from a medically necessary service. To be covered, the member must be either:

- (1) bed confined and unable to use another means of transportation, or
- (2) the member's condition must warrant ambulance transportation.

(b) OHCA's Non-emergency Transportation (NET) program, known as SoonerRide, is the first choice for non-emergency transportation for scheduled medical services. SoonerRide provides non-emergency transportation in accordance with all applicable criteria set forth in the American's with Disabilities Act (ADA).

(c) Regularly scheduled non-emergency medical services, such as outpatient dialysis, must be scheduled through SoonerRide unless the member's condition requires transport by stretcher or ambulance. All claims for scheduled trips for outpatient services that cannot be provided by SoonerRide must be accompanied by the medical documentation to substantiate the need for the higher level of transportation and will be reviewed prior to payment by OHCA.

(d) Ambulance or stretcher transport for unscheduled emergent medical care is covered if the trip meets all applicable criteria.

317:30-5-336.13. Non covered services

(a) Transportation by ambulance is not covered when the member's condition did not require that level of transportation and another mode of transportation would suffice.

(b) Ambulance transportation from residence to residence is not covered except for transfers from nursing home to nursing home when the transferring facility is not certified.

(c) Payment will not be made for ambulance transportation determined not to be medically necessary.

(d) Transportation to a funeral home, mortuary, or morgue is not covered.

317:30-5-337. Coverage for children

(a) Payment for ambulance transportation for children is made as described for adults in OAC 317:30-5-336(1). Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(b) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

317:30-5-339. Individuals eligible for Part B of Medicare

Payment for ambulance transportation is made utilizing the Medicaid allowable for comparable services using current Medicare methodology.

[OAR Docket #07-712; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-696]

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Subchapter 5. Individual Providers and Specialties
Part 39. Skilled and Registered Nursing Services
317:30-5-391 through 317:30-5-393 [AMENDED]
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N/A

ANALYSIS:

Agency Skilled and Registered Nursing Services rules are revised to establish a three-tier system to provide skilled nursing services to individuals demonstrating targeted medical needs enrolled in the Developmental Disabilities Services Division (DDSD) Homeward Bound and Community Waivers. One of the growing challenges in meeting the support needs of waiver service recipients is to provide adequate nursing support. Individuals who require nursing services have experienced changes to their health status and require skilled nursing intervention to prevent institutionalization. In recent years, DDSD has experienced a significant loss in the number of skilled nursing services providers, and continues to experience great difficulty in recruitment. DDSD has attempted to contract with other nursing agencies that have declined to service this population based on current reimbursement rates. To assure adequate nursing support for DDSD Waiver service recipients, a revision of the DDSD reimbursement structure is necessary.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 39. SKILLED AND REGISTERED NURSING SERVICES

317:30-5-391. Coverage for Skilled Nursing Services

(a) All Skilled Nursing Services must be ordered and prescribed by a physician, supported by a nursing plan of care, included in the Individual Habilitation Plan (IHP) individual plan as described in OAC 340:100-5-53 and reflected in the approved plan of care Plan of Care approved in accordance with OAC 340:100-3-33 and OAC 340:100-3-33.1. For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants and advanced practice nurses in accordance with the rules and regulations covering the OHCA's medical care program. Arrangements for care under this program waiver Skilled Nursing Services are made with the individual client's case manager through the personal support team with the specific involvement of the assigned Developmental Disabilities Services Division (DDSD) registered nurse (RN). The DDSD RN develops a nursing service support plan subject to review and authorization by the DDSD state nursing director or designee.

(b) All Registered Nursing (RN) Services must be ordered and prescribed by a physician, justified at a given level by the Physical Status Review, included in the Individual Habitation

Plan (IHP), and reflected in the approved plan of care. Arrangements for the provision of these services are made with the individual's case manager. Skilled Nursing Services are rendered in such a manner as to provide the service recipient as much autonomy as possible.

- (1) Skilled Nursing Services must be flexible and responsive to changes in the service recipient's needs.
- (2) Providers are expected to participate in annual personal support team meetings and other team meetings as required.
- (3) Appropriate supervision of Skilled Nursing Services including services provided by licensed practical nurses (LPNs) is provided pursuant to State law and regulatory board requirements.
- (4) Individual service providers must be RNs or LPNs currently licensed to practice in the State of Oklahoma.

317:30-5-392. Description of Skilled Nursing services

(a) Skilled nursing services include preventive and rehabilitative procedures which have been ordered and prescribed by a physician and documented in the client's Individual Habilitation Plan. Services are provided to eligible individuals age six and older. Services include ongoing assessment and documentation of any changes in the patient's physical or mental status; reports of all significant observations or changes in physical or mental status or needs of the individual and maintenance of the plan of care based on these reports; administering medications as ordered and specified by the attending physician; documenting administration of, responses to, adverse reactions to or explanations of medication; maintaining current and accurate medication records; maintaining documentation daily of the individual's status and duties as outlined in the nurse care plan; following annual nursing assessments and any needed interim written nursing assessments; implementing written plans of care; and providing leadership, supervision, training and motivation to direct care providers, participating in interdisciplinary team meetings to develop and revise Individual Habilitation Plans. Services include travel and benefits. Services are intended to contribute to the maintenance of the individual's physical health and well being. Services are provided in any community setting in which the service recipient resides.

(b) Registered Nursing (RN) Services include assessment, supervisory oversight, preventative, and nursing care procedures which have been ordered and prescribed by a physician and documented in the consumer's plan. Services are provided to eligible individuals and include ongoing assessment and treatment, documentation of the patients' physical or mental status, administering medications as ordered, preparing and presenting nursing assessment information, developing and implementing plans of care, providing leadership, supervision and training. Services are intended to contribute to the maintenance of the consumer's physical health and well being. Services may include direct skilled nursing services and also the provision of on-site supervision of LPN's. Direct service provision and supervision, on-site, is required in order to bill for this service. Off-site administration of clinical supervision is not included in this service.

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Types of Skilled Nursing Services in the waiver programs offered by the Oklahoma Department of Human Services' Developmental Disabilities Services Division (DDSD) are:

(1) **Extended Duty Skilled Nursing Care.** Extended Duty Skilled Nursing Care allows a licensed nurse to provide direct services in a community setting up to 24 hours per day.

(A) Extended Duty Skilled Nursing Care must be:

- (i) provided only to those service recipients who have health-related issues that require skilled treatment or other intervention by a licensed nurse more frequently than every two hours;
- (ii) ordered by a licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;
- (iii) justified in amount by the review done in accordance with OAC 340:100-5-26; and
- (iv) documented in the service recipient's Plan of Care.

(B) When Extended Duty Skilled Nursing Care is medically indicated in accordance with subparagraph (A) of this paragraph, Extended Duty Skilled Nursing Care includes:

- (i) skilled nursing care and interventions rendered directly to the service recipient by the nurse;
- (ii) monitoring, evaluation, and documentation of the service recipient's physical or mental status;
- (iii) administration of medication or treatments or both as ordered by the licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse;
- (iv) documentation of medication or treatment administration, skilled nursing interventions, service recipients's responses to medication or treatment, and any adverse reactions, or other significant changes;
- (v) implementation of all tasks and objectives of the written nursing plan of care; and
- (vi) performance of training and general care to the service recipient during periods in which skilled nursing tasks and interventions are not being performed.

(2) **Intermittent Skilled Nursing Care.** Intermittent Skilled Nursing Care involves performance of intermittent skilled tasks or interventions that only a licensed nurse can perform according to Section 1020 of Title 57 of the Oklahoma Statutes and OAC 340:100-5-26.3.

(A) Intermittent Skilled Nursing Care must be:

- (i) ordered by a licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse;
- (ii) justified in amount by the review done in accordance with OAC 340:100-5-26; and
- (iii) documented in the service recipient's Plan of Care.

(B) Intermittent Skilled Nursing Care includes:

- (i) skilled nursing care and interventions rendered directly to the service recipient, as ordered

by the licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;

- (ii) health-related assessments;
- (iii) administration of medication or treatments ordered by the licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;
- (iv) documentation of medication or treatment administration, the service recipient's response to medication or treatment, and any adverse reaction or other significant changes; and
- (v) implementation of all tasks and objectives of the nursing plan of care.

(3) **Individualized Skilled Nurse Training and Evaluation.** Individualized Skilled Nurse Training and Evaluation provides individualized evaluation and oversight of health care needs by a licensed nurse and specific, individualized health training by a licensed nurse to the service recipient or the service recipient's family or paid caregivers in accordance with Section 1020 of Title 56 of the Oklahoma Statutes and OAC 340:100-5-26.3.

(A) The licensed nurse assesses the service recipient's training needs prior to initiating competency-based training and develops a nursing plan of care that outlines the methods, goals, and objectives of the training to be performed. The nurse exercises prudent judgment in making the final decision as to what may be trained and delegated to community service workers, as provided by Section 1020 of Title 56 of the Oklahoma Statutes.

(B) Services include:

- (i) individualized nurse training or evaluation or both provided directly to the service recipient, family or paid caregiver(s), as identified in the individual plan and the nursing plan of care;
- (ii) evaluation and documentation of the competency of individuals trained through return demonstration, written test, verbalization of understanding, or other means suitable to the type of training performed;
- (iii) professional monitoring and supervision to the community service worker in accordance with the applicable licensing requirements and evaluation of:

- (I) the stability of the condition of the service recipient;
- (II) the training and capability of the person receiving training;
- (III) the nature of the task being trained; and
- (IV) the proximity and availability of the licensed nurse to the person when the task is being performed; and

- (iv) attendance at required meetings as specified in the individual plan.

317:30-5-393. Coverage limitations for Skilled Nursing Services

(a) A unit of Skilled Nursing Services is 30 minutes. Limits are specified in the recipient's IHP but may not exceed 48 units per day. Extended Duty Skilled Nursing Care cannot exceed three eight-hour shifts in a 24-hour period.

(b) A unit of Registered Nursing Service is a visit. Limits are specified in the consumer's Individual Habilitation Plan (IHP), but may not exceed one unit per day, 7 units per week, and 36 units per plan of care year. Intermittent Skilled Nursing Care is limited to no more than three skilled task site visits in a 24-hour period of time.

(c) Individualized Skilled Nurse Training and Evaluation is reimbursed on the basis of a 15-minute unit of service. No more than 16 units of Individualized Skilled Nurse Training and Evaluation can be provided per month, unless the exception is:

- (1) justified in writing by the team in accordance with OAC 340:100-3-33.1;
- (2) recommended by the DDS area nurse manager; and
- (3) meets the requirements of OAC 340:100-3-33.1.

[OAR Docket #07-696; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

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Part 61. Home Health Agencies
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N/A

ANALYSIS:

Home Health Agency provider rules are revised to allow Home Health Agencies who have been deemed eligible as a Home Health Medicare provider to contract with this agency to be a SoonerCare provider. Current Home Health Agency rules state that an agency must be Medicare certified or accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) in order to contract as a SoonerCare provider. Earlier this year, CMS revised federal regulations to approve the Accreditation Commission for Healthcare (ACHC) as a national accreditation program for home health agencies seeking to participate in the Medicare or Medicaid programs. Therefore, agency rules are revised to allow Home Health Agencies who have deemed status with Medicare to contract with SoonerCare, thus assuring SoonerCare members access to services.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 61. HOME HEALTH AGENCIES

317:30-5-545. Eligible providers

All eligible home health service providers must be Medicare certified, ~~or~~ accredited by the Joint Commission on Accreditation of Health Care ~~Organization~~ Organizations (JCAH—JCAHO), or have deemed status with Medicare, and have a current contract with the Oklahoma Health Care Authority. Home Health Agencies billing for durable medical equipment (DME) must have a supplier contract and bill equipment on claim form ~~HCFA-1500~~ CMS-1500. Additionally, home health services providers that did not participate in Medicaid prior to January 1, 1998, ~~but wish to become participating Medicaid providers of skilled home health services (those services defined within 42 CFR 440.70) on or after January 1, 1998,~~ must meet the "Capitalization Requirements" set forth in 42 CFR 489.28. Home health services providers that do not meet these requirements will not be permitted to participate in the Medicaid program.

[OAR Docket #07-704; filed 4-5-07]

Permanent Final Adoptions

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-703]

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RULES:

Subchapter 5. Individual Providers and Specialties

Part 62. Private Duty Nursing

317:30-5-556 [AMENDED]

317:30-5-558 [AMENDED]

317:30-5-560 [AMENDED]

317:30-5-560.1 [AMENDED]

317:30-5-560.2 [AMENDED]

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Part 62. Private Duty Nursing

317:30-5-556 [AMENDED]

317:30-5-558 [AMENDED]

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317:30-5-560.2 [AMENDED]

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N/A

ANALYSIS:

Agency rules are revised to add Private Duty Nursing (PDN) services to assist in transporting members to medical appointments and emergency room visits within the approved hours in the treatment plan and to require a new or revised treatment plan, signed by the physician, at least annually. Currently PDNs only provide services within the home. The revised rules enable nurses to assist with transporting members to medical appointments and emergency room visits in lieu of using an ambulance. Currently there is no time limitation on the duration of treatment plans. The current language could allow for inappropriate and/or outdated treatment plans and possible inappropriate PDN services. The revised rules will require physicians to keep treatment plans

updated with appropriate services for the member's condition provided by the PDN.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 62. PRIVATE DUTY NURSING

317:30-5-556. Definitions

The definition of private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in the patient's member's residence or to assist outside the home during transport to medical appointments and emergency room visits in lieu of transport by ambulance.

317:30-5-558. Private duty coverage limitations

(a) The following regulations apply to all private duty nursing services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the ~~Medicaid agency~~ Oklahoma Health Care Authority (OHCA). Prior authorization means authorization in advance of services provided in accordance with OAC 317:30-5-560.1;

(2) A treatment plan must be completed by the Nursing agency prior to the before requesting prior authorization and must be updated at least annually and signed by the physician throughout the course of nursing treatment;

(3) A personal visit by an ~~Oklahoma Health Care Authority Care~~ OHCA Care Management Nurse is required prior to the authorization for services;

(4) Care in excess of the designated hours per day granted in the prior authorization are is not Medicaid-compensable. The banking, saving or accumulation of unused prior authorized hours to be used later are not compensable Prior-authorized but unused service hours cannot be "banked," "saved," or otherwise "accumulated" for use at a future date or time. If such hours or service are provided, they are not Medicaid-compensable.

(5) ~~The agency requesting prior authorization must have adequate staff and resources to meet the Plan of Care requirements. Failure to provide care in the manner described on the Plan of Care will result in termination of the prior authorization and selection of another provider~~ Any care provided outside of the home is limited to assisting during transport to medical appointments and emergency room visits in lieu of transport by ambulance

and is limited to the number of hours requested on the treatment plan and approved by OHCA.

(6) Private duty nursing services ~~does do~~ not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefits the ~~person member~~ receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will ~~the Authority~~ OHCA compensate an organization for nursing staff time when sleeping.

(8) OHCA will not ~~compensate~~ approve Private Duty Nursing service if all health and safety issues cannot be met in the home setting.

(9) A provider ~~may must~~ not misrepresent or omit facts in a treatment plan ~~or omit facts from a treatment plan~~.

(10) It is outside the scope of coverage to deliver care in a manner outside the treatment plan or to deliver units over the authorized units of care.

(11) Private duty nursing ~~will is~~ not be authorized in excess of 16 hours per day except immediately following a hospital stay or the temporary incapacitation of the primary caregiver. Under these two exceptions, care in excess of 16 hours ~~may be~~ is authorized for a period up to 30 days. As expressed in this subsection, incapacity means an involuntary ability to provide care.

(12) Family and/or caregivers and/or guardians are required to provide some of the nursing care to the member without compensation.

~~(b) A violation of any private duty nursing coverage limitation will result in an overpayment. Continued violations may result in contract termination.~~

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the patient member as part of the authorization process ~~to have for~~ private duty nursing services ~~authorized~~. The initial treatment plan must be signed by the patient's member's attending physician. It must be updated and signed annually.

(b) The treatment plan must include all of the following medical and social data so that OHCA Care Managers can appropriately determine medical necessity by the use of the Private Duty Nursing Acuity Grid:

- (1) diagnosis;
- (2) prognosis;
- (3) anticipated length of treatment;
- (4) number of hours of private duty nursing requested per day;
- (5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);
- (6) medication method of administration and frequency;
- (7) age-appropriate feeding requirements (diet, method and frequency);

- (8) respiratory needs;
- (9) mobility requirements including need for turning and positioning, and the potential for skin breakdown;
- (10) developmental deficits;
- (11) casting, orthotics, therapies;
- (12) age-appropriate elimination needs;
- (13) seizure activity and precautions;
- (14) age-appropriate sleep patterns;
- (15) disorientation and/or combative issues;
- (16) age-appropriate wound care and/or personal care;
- (17) communication issues;
- (18) social support needs;
- (19) name, skill level, and availability of all caregivers; and
- (20) other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

(a) Authorizations are provided for a maximum period of six months.

(b) Authorizations ~~may only be received by creating~~ require:
(1) a treatment plan for the patient member; and
(2) requesting a visit by an OHCA Care Management Nurse; and having to determine medical necessity the Care Management Nurse using the Private Duty Nursing Acuity Grid.

(c) The number of hours ~~requested on the treatment~~ authorized plan may be ~~modified~~ differ from the hours requested on the treatment plan based on the assessment of ~~OHCA staff~~ during a visit by a the Care Management Nurse.

(d) If the patient's member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.

(e) Changes in the treatment plan may necessitate another visit by the Care Management staff.

317:30-5-560.2. Record documentation

~~Copies of the treatment plan signed by the attending physician. The treatment plan must be updated and signed by the attending physician at least annually.~~ Copies of the attending physician's orders and, at a minimum, the last 30 days of medical records for the actual care provided must be maintained in the home. Medical records must include the beginning and ending time of the care and must be signed by the person providing care. The nurse's credentials must also be included. All provisions of the treatment plan, such as vital signs, medication administration, glucose/neuro checks, vital signs, respiratory assessments, and all applicable treatments must be documented in the record. All records must meet the requirements set forth in OAC 317:30-3-15.

[OAR Docket #07-703; filed 4-5-07]

Permanent Final Adoptions

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-697]

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Subchapter 5. Individual Providers and Specialties

Part 77. Speech and Hearing Services

317:30-5-676 [AMENDED]

(Reference APA WF # 06-06)

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Part 77. Speech and Hearing Services

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N/A

ANALYSIS:

Agency rules are revised to remove the prior authorization requirement for initial speech and hearing services for children. Currently, rules state that all speech and hearing services, including the initial evaluation, for children must be prior authorized by the agency's Medical Authorization Unit. All requests for an evaluation are routinely approved which creates a large volume of unnecessary work for the unit. Revisions allow reimbursement for the initial therapy evaluation and the first three speech and hearing visits without prior authorization. These revisions are needed to remove an unnecessary prior authorization to an evaluation that is always allowed through the Early Periodic Screening and Diagnostic Testing program for children. Additional visits continue to require prior authorization.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
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OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 77. SPEECH AND HEARING SERVICES

317:30-5-676. Coverage by category

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** ~~All speech and hearing services must be preauthorized. Initial therapy evaluations and the first three therapy visits do not require prior authorization. All therapy services following the initial evaluation and first three visits must be preauthorized prior to continuation of service.~~

(B) **Speech/Language Services.** Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients ~~should be~~ are filed directly with the fiscal agent.

[OAR Docket #07-697; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-694]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 85. ADvantage Program Waiver Services

317:30-5-763 through 317:30-5-764 [AMENDED]

Part 95. Agency Personal Care Services

317:30-5-951 through 30-5-953 [AMENDED]

(Reference APA WF # 06-13A)

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Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.167

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Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
317:30-5-763 through 317:30-5-764 [AMENDED]
Part 95. Agency Personal Care Services
317:30-5-951 through 30-5-953 [AMENDED]

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Personal Care Services rules are revised at the request of the Oklahoma Department of Human Services (OKDHS) to shift the responsibility for the completion of the skilled nursing assessment and service planning from state employed OKDHS registered nurses to provider agency nurses. Existing rules require the OKDHS Long Term Care registered nurse to make a home visit to assess the member's needs, and develop and monitor the care and service plans. Once eligibility is determined for Personal Care Services, the individual chooses an agency Personal Care service provider who is reimbursed to provide the needed services and also monitor the service recipient's care and service plans, duplicating the efforts of the OKDHS Long Term Care nurse. Most individuals receiving Medicaid State Plan Personal Care services require assistance with the instrumental activities of daily living such as meal preparation, cleaning and chore services and do not require hands on care. The Nurse Practice Act does not require a registered nurse to complete the tasks of service planning, monitoring and plan development. By transferring additional responsibility to the Personal Care service agencies, the OKDHS registered nurses will have more time to concentrate on their numerous other responsibilities that require the expertise of registered nurses. Revisions are needed in order for the Oklahoma Department of Human Services to transfer the responsibility of the care plan development and monitoring to home care provider agency nurses.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) Case Management.

(A) Case Management services are services that assist a client member in gaining access to medical, social educational or other services, regardless of payment source of services, that may benefit the client member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the client's member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the client member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the client's—member's condition and available support. Case managers monitor the client's—member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a client member requires hospital or nursing facility services, the case manager assists the client member in accessing institutional care and, as appropriate, periodically monitors the client's member's progress during the institutional stay and helps the client member transition from institution to home by updating the service plan and preparing services to start on the date the client member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage clients members. Prior to providing services to clients members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case Management activities described as follows:

- (i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a client-member;
- (ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the

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administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the client member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a client member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a client member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to clients members that reside in AA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these clients members are prior authorized and billed using the Standard rate.

(iii) The United States 2000 Census, Oklahoma Counties population data is the source for determination of whether a client member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) Respite.

(A) Respite services are provided to clients members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the client member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the client's member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the client's member's home.

(3) Adult Day Health Care.

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week, at least four hours per day in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the client member. Physical, occupational, respiratory and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service shall not constitute a full nutritional regimen. Transportation between the client's member's residence and the service setting is provided as a part of Adult Day Health Care. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver client member who uses adult day health care requires assistance with bathing and/or hair washing to maintain health and safety.

(B) Adult Day Health Care is a 15 minute unit. No more than 6 hours are authorized per day. The number of units of service a client member may receive is limited to the number of units approved on the client's member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

(4) Environmental Modifications.

(A) Environmental Modifications are physical adaptations to the home, required by the client's member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the client member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client member are excluded.

(B) All services require prior authorization.

(5) Specialized Medical Equipment and Supplies.

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable clients members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included

are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service shall exclude any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver ~~client~~ member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. All services must be prior authorized.

(6) **Comprehensive Home Care.** Comprehensive Home Care is an integrated service-delivery package which includes case management, personal care, skilled nursing, in-home respite and advanced supportive/restorative assistance.

(A) Comprehensive Home Care is provided by an agency which has been trained and certified by the Long Term Care Authority to provide an integrated service delivery system. Comprehensive Home Care is case management in combination with one or more of the following services:

- (i) personal care,
- (ii) in-home respite,
- (iii) skilled nursing, and/or
- (iv) advanced supportive/restorative services.

(B) All services must be provided in the home and must be sufficient to achieve, maintain or improve the ~~client's~~ member's ability to carry out daily living activities. However, with OKDHS area nurse approval, or for ADvantage waiver ~~clients~~ members, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the ~~client~~ member in achieving vocational goals identified on the service plan. The sub-component services of Comprehensive Home Care are the same as described in (A) of this paragraph (see subparagraph (1)(A) of this section for Case Management services, OAC 317:35-15-2 for Personal Care service, subparagraph (8)(A) of this section for Skilled Nursing, subparagraph (2)(A) of this section for In-Home Respite, and subparagraph (7)(A) of this section for Advanced Supportive/Restorative Assistance).

(C) CHC services are billed using the appropriate HCPC procedure code along with the CHC provider location code on the claim.

(7) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a ~~client~~ member who has a chronic, yet stable, condition. The service assists with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a ~~client~~ member may

receive is limited to the number of units approved on the plan of care.

(8) **Skilled Nursing.**

(A) Skilled Nursing services are services of a maintenance or preventive nature provided to ~~clients~~ members with stable, chronic conditions. These services are not intended to be treatment for an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide, assessment of the ~~client's~~ member's health and assessment of services to meet the ~~client's~~ member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each ~~client~~ member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the ~~client~~ member. ~~A monthly~~ An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the ~~client's~~ member's condition or other significant information concerning each advanced supportive/restorative care ~~client~~ member.

(i) The ADvantage Program case manager may recommend authorization of Skilled Nursing services for participation in interdisciplinary team planning of service plan and/or assessment/evaluation of:

- (I) the ~~client's~~ member's general health, functional ability and needs and/or
- (II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the ~~client's~~ member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the ADvantage Program case manager may recommend authorization of Skilled Nursing services for the following:

- (I) filling a one-week supply of insulin syringes for a blind diabetic who can self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the ~~client's~~ member's continued ability to self-administer the insulin;
- (II) setting up oral medications in divided daily compartments for a ~~client~~ member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

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(III) monitoring a client's member's skin condition when a client-member is at risk of skin breakdown due to immobility or incontinence, or the client member has a chronic stage II decubitus requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic client member or client-member with circulatory or neurological deficiency;

(V) providing consultation and education to the client member, client's member's family and/or other informal caregivers identified in the service plan, regarding the nature of the chronic condition. Provide skills training (including return skills demonstration to establish competency) for preventive and rehabilitative care procedures to the client member, family and/or other informal caregivers as specified in the service plan.

(B) Skilled Nursing service is billed for ~~an service plan development and/or assessment/evaluation services per assessment~~ or, for non-assessment services, ~~Skilled Nursing services are billed for the first hour unit of service and for each per 15-minute unit of service provided after the first hour. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure code is used to bill for all other authorized skilled nursing services. A minimum of three and a maximum of seven units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed.~~ An agreement by a provider to produce a nurse evaluation is an agreement, as well, to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation shall be denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted.

(9) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day brought to the client's-member's home. Each meal has a nutritional content equal to one third of the Recommended Daily Allowance. Meals are only provided to clients members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal/unit. The limit of the number of units a client member is allowed to receive is limited on the client's member's plan of care.

(10) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of clients members with physical

disabilities and related psychological and cognitive impairments. Services are provided in the client's member's home and are intended to help the client member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the client member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the client's member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the client's member's rehabilitative progress and will report to the client's member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the client's member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(11) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of clients members disabled by pain, disease or injury. Services are provided in the client's member's home and are intended to help the client member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the client's member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the client's member's rehabilitative progress and will report to the client's member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the client's member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(12) Comprehensive Home Care (CHC) Personal Care.

(A) Comprehensive Home Care (CHC) Personal Care is assistance to a ~~client-member~~ in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the ~~client member~~ or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) CHC Case Manager and Skilled Nursing staff are responsible for development and monitoring of the ~~client's member's~~ CHC Personal Care plan.

(C) Comprehensive Home Care (CHC) Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(13) Speech and Language Therapy Services.

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of ~~clients-members~~ disabled by pain, disease or injury. Services are provided in the ~~client's-member's~~ home and are intended to help the ~~client member~~ achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language therapist evaluates the ~~client's member's~~ rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed speech/language therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the ~~client's member's~~ rehabilitative progress and will report to the ~~client's member's~~ case manager and physician to coordinate necessary addition and/or deletion of services, based on the ~~client's member's~~ condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(14) Respiratory Therapy Services.

(A) Respiratory therapy services are provided for a ~~client member~~ who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the ~~client's-member's~~ home under the

care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the ~~client member~~. Treatment involved use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the ~~client member~~ and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the ~~client's member's~~ progress and will report to the ~~client's member's~~ case manager and physician to coordinate necessary addition and/or deletion of services, based on the ~~client's-member's~~ condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(15) Hospice Services.

(A) Hospice is palliative and/or comfort care provided to the ~~client member~~ and his/her family when a physician certifies that the ~~client member~~ has a terminal illness and has six months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The ~~client member~~ signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the ~~client's member's~~ illness. Once the ~~client-member~~ has elected hospice care, the hospice medical team assumes responsibility for the ~~client's member's~~ medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the ~~client member~~ and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the ~~client's member's~~ ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the ~~client's member's~~ terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the ~~client member~~ in a Nursing Facility (NF) only when the ~~client-member~~ is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed

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for more than five days during any 30 day period. A client member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(B) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the Hospice provider is responsible for providing Hospice services as needed by the client member or client's member's family.

(16) ADvantage Personal Care.

(A) ADvantage Personal Care is assistance to ~~an individual~~ a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are responsible for development and monitoring of the client's member's Personal Care plan.

(C) ADvantage Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(17) Personal Emergency Response System.

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with client member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program client member to be eligible to receive PERS service, the client member must meet all of the following service criteria:

- (i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;
- (ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) has a health and safety plan detailing the interventions beyond the PERS to assure the client's member's health and safety in his/her home;
- (v) has a disease management plan to implement medical and health interventions that reduce

the possibility of falls by managing the client's member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the client member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

(18) Consumer-Directed Personal Assistance Services and Support (CD-PASS).

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance, Advanced Personal Services Assistance and Employer Support Services that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The client member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Employer Support Services provider, for ensuring that the employment complies with State and Federal Labor Law requirements. The client member may designate an adult family member or friend, an individual who is not a PSA or APSA to the client member, as an "authorized representative" to assist in executing these employer functions. The client member:

- (i) recruits, hires and, as necessary, discharges the PSA or APSA;
- (ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ~~Advantage~~ ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the SPSA must demonstrate competency in the tasks in an on-the-job training session conducted by the client member and the client member must document the attendant's competency in performing each task in the ASPA's personnel file;
- (iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;
- (iv) supervises and documents employee work time; and,
- (v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

- (i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;

(ii) assistance with routine bodily functions that may include:

- (I) bathing and personal hygiene;
- (II) dressing and grooming;
- (III) eating including meal preparation and cleanup;

(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;

(iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the client member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a client member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Clients Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

- (i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
- (ii) remove external catheters, inspect skin and reapplication of same;
- (iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with clients members without contraindicating rectal or intestinal conditions;
- (iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
- (v) use lift for transfers;

- (vi) manually assist with oral medications;
- (vii) provide passive range of motion (non-resistant flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;
- (viii) apply non-sterile dressings to superficial skin breaks or abrasions; and
- (ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Employer Support Services is assistance with employer related cognitive tasks, decision-making and specialized skills that may include:

- (i) assistance with Individual Budget Allocation planning and support for making decisions, including training, reference material and consultation, regarding employee management tasks such as recruiting, hiring, training and supervising the Personal Service Assistant or Advanced Personal Service Assistant;
- (ii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the client member, on prospective hires for PSAs or APSAs;
- (iii) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards;
- (iv) for performing Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

- (I) employer payroll, at a minimum of semi monthly, and associated mandatory withholding for taxes, Unemployment Insurance and Workers' Compensation Insurance performed on behalf of the client member as employer of the PSA or APSA; and
- (II) other employer related payment disbursements as agreed to with the client member and in accordance with the client's member's Individual Budget Allocation.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a client member may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a client member may receive is limited to the number of units approved on the Service Plan.

(G) The service of Employer Support Services is billed per month unit of service. The Level of service and number of units of Employer Support Services a client member may receive is limited to the Level and number of units approved on the Service Plan.

(19) Institution Transition Services.

(A) Institution Transition Services are those services that are necessary to enable an individual to

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leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community. Institution Transition Services may include, as necessary, any one or a combination of the following:

- (i) Case Management;
- (ii) Nursing Assessment and Evaluation for in-home service planning;
- (iii) Environmental Modifications including Assessment for Transition Environmental Modification Services; and/or,
- (iv) Medical Equipment and Supplies.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage ~~client's~~ member's progress during an institutional stay, and for assisting the ~~client~~ member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the ~~client~~ member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received Advantage services but have been referred by the AA or OKDHS to the Case Management Provider for assistance in transitioning from the institution to the community with Advantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15 minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the ~~client~~ member served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institution Transition Skilled Nursing Services are nursing services, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Institutional

Transition Skilled Nursing services are solely for assessment/evaluation and service planning for in-home assistance services.

(i) Institution Transition Skilled Nursing services are prior authorized and billed per assessment/evaluation visit using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Skilled Nursing Services from regular Skilled Nursing Services.

(D) Institution Transition Environmental Modifications are those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Such adaptations are the same as described under OAC 317:30-5-763(4)(A) and may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Services may include accessibility evaluation of the ~~client's~~ member's home and follow-up evaluation of the adequacy of installed environmental modifications to meet the ~~client's~~ member's accessibility and environmental adaptive needs. Accessibility evaluation services must be performed by an Accessibility Specialist who is trained and certified through a Federal or State agency approved program for Americans with Disabilities Act (ADA) Accessibility Guidelines - Title III (Public Accommodations) or by a physical or occupational therapist. Accessibility evaluation services do not include evaluations of the need for modifications or equipment that serve a therapeutic or rehabilitative function for which a therapist evaluation is necessary.

(i) Institution Transition Environmental Modification services are prior authorized and billed using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Environmental Modification Services and Assessments from regular Environmental Modification Services and Assessments.

(E) Institution Transition Specialized medical equipment and supplies are those devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform

activities of daily living, or to perceive, control, or communicate with the environment in which they live, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Item reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

- (i) Institution Transition Medical Equipment and Supply services are prior authorized and billed using the appropriate HCPC.
 - (ii) A unique modifier code is used to distinguish Institution Transition Medical Equipment and Supply Services from regular Medical Equipment and Supply services.
- (F) Institutional Transition Services may be authorized and reimbursed under the following conditions:
- (i) The service is necessary to enable the individual to move from the institution to their home;
 - (ii) The individual is eligible to receive Advantage services outside the institutional setting;
 - (iii) Institutional Transition Services are provided to the individual within 120 days of discharge from the institution;
 - (iv) Transition Services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.
- (G) If the client member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services authorized and provided are reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the AA to bill for services provided.

317:30-5-764. Reimbursement

- (a) Rates for waiver services are set in accordance with the rate setting process by the Committee for Rates and Standards and approved by the Oklahoma Health Care Authority Board.
- (1) The rate for NF Respite is set equivalent to the rate for enhanced nursing facility services that require providers having equivalent qualifications;
 - (2) The rate for daily units for Adult Day Health Care are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Adult Day Service Program that require providers having equivalent qualifications;
 - (3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma

Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;

- (4) The rates for units of In-Home Respite, CHC Personal Care, and CHC In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;
- (5) The rates for a unit of Skilled Nursing and CHC Skilled Nursing are set equivalent to ~~State Plan Home Health Benefit Skilled Nursing unit that require providers having equivalent qualifications~~ the ADvantage Case Management Standard rate.
- (6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each client member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:
 - (A) Authorized PSA and APSA units (determined from CDA/CM and client member planning);
 - (B) Total CD-PASS IBA (annualized authorized units X the rate for comparable agency personal assistance services). The Total CD-PASS IBA (TIBA) is the annualized budget amount calculated to cover reimbursement for all CD-PASS services - Personal Services Assistance (PSA), Advanced Personal Services Assistance (APSA) and Employer Support Services (ESS). The TIBA is equal to that portion of the annualized cost for Personal Care services and Advanced Supportive/Restorative assistance under the client's member's existing service plan that CD-PASS services replace;
 - (C) Authorized Employer Support Service level (based on AA assessment of client's member's level of need for Employer Supportive Services from review of Consumer Readiness assessment for those new to CD-PASS or performance if existing CD-PASS participant);
 - (D) Total Annual ESS budget allocation (annualized ESS authorized units X the ESS level rate) and
 - (E) Client IBA (CIBA) which is equal to the Total CD-PASS IBA minus Total ESS allocation (E=B-D).
 - (F) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS to be equal to or less than expenditures for equivalent services using agency providers. The TIBA and service unit rates are calculated by the AA during the CD-PASS service eligibility determination process. Based upon the client member record review, client member "Self-assessment of Readiness" to assume employer role and responsibilities and other available information, the AA authorizes a level of support to cover Employer Support Service needs. This process establishes the monthly rate for Employer Support Services. Thereafter, as part of the service planning authorization process at a minimum of annually, the AA, in consultation with the client member reviews and updates the authorized level of Employer Support Services.

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(G) The PSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Personal Care (PC) services under the ~~client's~~ member's existing service plan and the result is divided by the total number of PC units authorized per month.

(i) The allocation of portions of PSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each ~~client~~ member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;

(ii) If both APSA and PSA units are being authorized the ESS monthly rate amount employed in the PSA rate determination is in proportion to the units of PSA to combined PSA plus APSA units;

(H) The APSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Advanced Supportive/Restorative (ASR) assistance services under the ~~client's~~ member's existing service plan and the result divided by the total number of ASR units authorized per month.

(i) The allocation of portions of APSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each ~~client~~ member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;

(ii) If both APSA and PSA units are being authorized, the ESS monthly rate amount employed in the APSA rate determination is in proportion to the units of APSA to combined PSA plus APSA units.

(I) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the ~~consumer's~~ member's need for CD-PASS services. If the ~~client's~~ member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional ~~client~~ member need. The AA, upon favorable review, authorizes the amended plan and updates the ~~client's~~ member's IBA. Service amendments based on changes in ~~client~~ member need for services do not change an existing PSA or APSA rate. The ~~client~~ member, with assistance from the ESSP, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(b) The AA approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to SURS for follow-up investigation.

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-951. Coverage by category

~~Medicaid~~ SoonerCare payment is made to agencies, on behalf of ~~Medicaid recipients~~ SoonerCare members, for personal care services (PC services) provided in the ~~recipient's~~ member's home. Personal Care services may be provided in an educational or employment setting to assist the ~~client~~ member in achieving vocational goals identified on the ~~service plan~~ with the approval of the ~~DHS area nurse~~ an approved care plan. Personal care services prevent, or minimize, a ~~member's~~ member's physical health regression and deterioration. Tasks performed during the provision of ~~personal care~~ PC services include, but are not limited to, assisting an individual in performing tasks of personal hygiene, dressing and medication. Tasks may also include meal preparation, light housekeeping, errands, and laundry directly related to the recipient's personal care needs. Personal care does not include the provision of care of a technical nature. For example, tracheal suctioning, bladder catheterization, colostomy irrigation and operation/maintenance of technical machinery is not performed as part of ~~personal care~~ PC services. PC skilled nursing service is an assessment of the member's needs to determine the frequency of PC services and tasks performed, development of a PC service care plan to meet identified personal care needs, service delivery oversight and annual re-assessment and updating of care plan. It may also include more frequent re-assessment and updating of the care plan if changes in the member's needs require.

(1) **Adults.** Payment for ~~agency personal care~~ services provided by a PC services agency is made on behalf of ~~aged or disabled~~ eligible individuals who have ~~been assessed using needs requiring the service in accordance with OAC 317:35-15-4 as determined through an assessment utilizing the Uniform Comprehensive Assessment Tool (UCAT) and whose needs, as determined through the assessment, require the provision of this service, in accordance with OAC 317:35-15-4. To be eligible for personal care~~ Before PC services can begin the individual must:

(A) require a ~~treatment~~ care plan involving the planning and administration of services delivered under the supervision of professional personnel ~~and are prescribed by the physician;~~

(B) have a physical impairment or combination of physical and mental impairments;

- (C) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and
- (D) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(2) **Children.** Coverage for persons under 21 years of age is the same as for adults.

317:30-5-952. Prior authorization

~~Each client Eligible members~~ receiving personal care services must have ~~a treatment an approved care plan~~ developed by a ~~Department of Human Services (DHS) Long Term Care (LTC) PC services skilled nurse.~~ For persons ~~receiving ADvantage Program services,~~ the nurse works with ~~the member's or by an~~ ADvantage Program Case Manager ~~to develop the care plan.~~ The amount and frequency of the service, to be provided to the ~~client member,~~ is listed on the ~~treatment care plan.~~ The amount and frequency of PC services is ~~also prior authorized approved~~ by the ~~LTC OKDHS~~ nurse or by the ~~Administrative Agent's (AA) certification authorization~~ of the ADvantage Program Service Plan. ~~At the time of a PC services member's initial referral to a PC services agency, OKDHS or AA authorizes PC services, skilled nursing for PC services, needs assessment and care plan development.~~ The number of units of ~~service PC services or PC skilled nursing~~ the ~~client member~~ is eligible to receive is limited to the ~~service time~~ amounts approved on the ~~nurse's prior authorization or on the AA certified ADvantage Program Service Plan converted to 15 minute units care plan as authorized by OKDHS or AA.~~ ~~Care plans are authorized for no more than one year from the date of care plan authorization.~~ Services provided without prior authorization are not compensable.

317:30-5-953. Billing

~~Agency personal care unit of service is one hour. A billing unit of service for personal care skilled nursing service equals a visit. A billing unit of service for personal care services provided by a PC service agency is 15 minutes of PC services delivery.~~ Billing procedures for Personal Care services are contained in the OKMMIS Billing and Procedure Manual.

[OAR Docket #07-694; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**

[OAR Docket #07-706]

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RULES:

Subchapter 3. Coverage and Exclusions
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N/A

ANALYSIS:

Non-emergency transportation (NET) rules are revised to exclude the capitated payment and transportation services for individuals who reside in an Institution for Mental Disease (IMD). Federal regulations state that Federal Financial Participation is unavailable for individuals in an IMD (42 CFR 435.1008). Therefore, to comply with federal regulations, NET rules are revised to exclude the capitated payment and transportation services for individuals residing in Institutions for Mental Disease.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-2. Medicaid SoonerCare transportation and subsistence

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible ~~Medicaid recipients~~ SoonerCare members who are not otherwise covered through their Managed Care Plan and who are in need of Medicaid-SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts

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~~with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. Payment for covered services to the broker is reimbursed under a capitated methodology based on per member per month. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. Ambulance and air providers are reimbursed at a rate published statewide based on the Medicare established rates for covered services. Transportation must be for medically necessary treatment in accordance with 42 CFR 440.170 Reimbursement for transportation costs must be prior authorized by the local Department of Human Services' (OKDHS) county director. Transportation costs must be for a medically necessary examination or treatment and only when transportation is not otherwise available. Payment through Medicaid may be made for transportation by private vehicle, bus, taxi, ambulance or airplane. Payment is made for a private vehicle at the Medicaid fee schedule rate and for public carrier at the public carrier rate. Individuals transporting more than one authorized recipient, from and to one destination and back, at the same time are reimbursed for only one trip. When transporting more than one authorized recipient, from and to and back to different locations, at the same time, reimbursement is made for one round trip. Beginning June 1, 1999, the Oklahoma Health Care Authority (OHCA) will begin a pilot transportation broker project with the Metropolitan Tulsa Transit Authority (MTTA) known as SoonerRide. SoonerRide will exclude excludes individuals who are enrolled in a Managed Care Organization (MCO) through OHCA, those individuals who are categorized as institutionalized, Home and Community Based Waiver members with the exception of the In-home Supports Waiver for Children and the ADvantage Waiver, and those individuals who are categorized as Qualified Medicare Beneficiaries Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB), and Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD). Clients Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which will be is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the client member is required to notify SoonerRide at least 72 hours prior to the appointment. The client member will be is asked to furnish the SoonerRide reservation center the ease their SoonerCare member number, home address, the time and date of the medical appointment, the address of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide will make makes arrangements for the most appropriate, least costly transportation. SoonerRide will verify verifies appointments when appropriate. The SoonerRide contractor will be is responsible for recruiting providers in each county and ensuring that all transportation providers meet all appropriate regulations for the provision of public transportation. Provider qualifications will include, but is are not limited to, verification of liability insurance and drug~~

~~testing. All non-emergency transportation will be arranged by SoonerRide. If the client member disagrees with the transportation arranged or denied by SoonerRide, an appeal should be is filed with OHCA within 48 hours of the notification. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the client member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision will be is final. As provider networks are developed, SoonerRide will be expanded to include additional counties. Before a county is phased into SoonerRide, county officials and clients will be notified. A public meeting will be held prior to inclusion of each new county.~~

~~(1) Authorization for transportation by private vehicle or bus.~~

~~(A) Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services. Reimbursement for transportation by a private vehicle (privately owned, leased or rented) may be made directly to the client or to another person providing the private transportation for the client. Authorization cannot be made to a OKDHS or OHCA employee or the spouse of a OKDHS or OHCA employee, unless he/she is a certified volunteer, or any employee of another county, state or federal agency who is providing the transportation as a part of the regular duties within that agency. Private transportation is authorized at the Medicaid fee schedule rate from and to the transporter's point of origin. Claim for payment is filed on a travel reimbursement form, after it has been documented that the individual kept the appointment(s) for the medical services. Transportation by a private vehicle may be authorized when the recipient:~~

- ~~(i) lives in a rural area where needed Medicaid medical examination or treatment is not available and the recipient must travel outside his/her local community to receive the needed medical services.~~
- ~~(ii) receives Medicaid medical services within his/her own community, and it has been documented that the transportation cannot be made available through the individual's own efforts or through community volunteer resources.~~

~~(B) The distances for which reimbursement is claimed may not exceed the distances set forth in the latest Transportation Commission road map. Travel claimed between points not shown on the official map shall be based on actual odometer readings. Vicinity travel is entered on travel claims as a separate item from road map mileage, for city and rural traveling within a small area, and is computed using mileage on the basis of actual odometer readings.~~

~~(C) Travel is reimbursed on the basis of the actual number of miles traveled from the transporter's point of origin to the first official call, subsequent official calls, and return to the point of origin. Recipients or transporters returning to a destination other than~~

the original starting point (with local OKDHS County Director approval) must provide a brief explanation on the travel reimbursement form.

~~(D) Reimbursement for out of state transportation (not to exceed 100 map miles) that is medically necessary and would not require reimbursement for per diem may be authorized when the transportation is deemed in the best interest of the recipient and the OHCA.~~

~~(2) **Reimbursement for public transportation.**~~

~~(A) **Authorization for transportation by bus.** Transportation by bus is authorized when it is necessary for an eligible individual to receive treatment in a medical facility. (If the services of an escort are necessary, see (6) of this Section).~~

~~(2B) **Authorization for transportation by taxi.** Taxi service may be authorized only when transportation cannot be arranged through the individual's own efforts or through community resources at the discretion of the broker. When taxi service is necessary to transport recipients to and from their home to the medical provider or to the nearest point of common carrier access or a common carrier to the medical provider, reimbursement is paid on the basis of actual expenses. A memo giving a detailed explanation of why the taxi service had to be used must be attached to the travel reimbursement form. Taxicab charges must be itemized on the travel reimbursement form and are reimbursed only upon justification as to the necessity of their use.~~

~~(3) **Transportation by ambulance (ground, air ambulance or helicopter).** Transportation by ambulance is compensable for individuals eligible for Medicaid SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility (a physician's office or clinic is not considered a medical facility) for medical care compensable under SoonerCare.~~

~~(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA, Medical Authorization Unit, who will make the necessary flight arrangements.~~

~~(5) **Subsistence (sleeping accommodations and meals).** An individual who is eligible for transportation to or from a medical facility to obtain medical services may receive assistance with the necessary expenses of lodging and meals from Medicaid SoonerCare funds. If the individual needs assistance with necessary expenses of lodging and meals, the member must first pay for the lodging and meals and then submit a travel reimbursement form for reimbursement does not have the funds for the necessary subsistence, authorization is made by the local office on Room and Board Order form. The travel reimbursement form may be obtained by contacting OHCA or the local OKDHS office. The individual may choose to pay for the lodging and meals and be reimbursed by filing~~

~~a travel reimbursement form.~~ Any subsistence expense claimed on the travel reimbursement form must be documented with receipts, and reimbursement cannot exceed state per diem amounts. Payment for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

~~(6) **Escort assistance required.** Payment for transportation and subsistence of one escort may be authorized if the service is required. Only one escort may be authorized. It is the responsibility of the OHCA Oklahoma Department of Human Services' social worker to determine this necessity. The decision should be based on the following circumstances:~~

- ~~(A) when the individual's health does not permit traveling alone; and~~
- ~~(B) when the individual seeking medical services is a minor child.~~

[OAR Docket #07-706; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**

[OAR Docket #07-695]

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- Subchapter 15. Personal Care Services
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- 317:35-15-8 through 317:35-15-8.1 [AMENDED]
- 317:35-15-10 [AMENDED]
- 317:35-15-13.1 [AMENDED]

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- 317:35-15-2 [AMENDED]

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317:35-15-8 through 317:35-15-8.1 [AMENDED]

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317:35-15-13.1 [AMENDED]

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ANALYSIS:

Personal Care Services rules are revised at the request of the Oklahoma Department of Human Services (OKDHS) to shift the responsibility for the completion of the skilled nursing assessment and service planning from state employed OKDHS registered nurses to provider agency nurses. Existing rules require the OKDHS Long Term Care registered nurse to make a home visit to assess the member's needs, and develop and monitor the care and service plans. Once eligibility is determined for Personal Care Services, the individual chooses an agency Personal Care service provider who is reimbursed to provide the needed services and also monitor the service recipient's care and service plans, duplicating the efforts of the OKDHS Long Term Care nurse. Most individuals receiving Medicaid State Plan Personal Care services require assistance with the instrumental activities of daily living such as meal preparation, cleaning and chore services and do not require hands on care. The Nurse Practice Act does not require a registered nurse to complete the tasks of service planning, monitoring and plan development. By transferring additional responsibility to the Personal Care service agencies, the OKDHS registered nurses will have more time to concentrate on their numerous other responsibilities that require the expertise of registered nurses. Revisions are needed in order for the Oklahoma Department of Human Services to transfer the responsibility of the care plan development and monitoring to home care provider agency nurses.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-2. Personal Care services

(a) Personal Care is ~~defined as~~ assistance to an individual in carrying out activities of daily living, such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry or errands directly related to the member's personal care needs, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. The Personal Care service requires a skilled nursing assessment of need, development of a care plan to meet identified personal care needs, care plan oversight and periodic re-assessment and updating, if necessary, of the care plan. Personal Care services do not include technical service services provision of a technical nature, i.e. such as, tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance operation of equipment of a technical nature.

(b) Personal Care is a level of care for individuals who do not require care in a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR). Personal Care

~~services are initiated to support the informal care that is being provided in the client's member's home. A rented apartment, room or shelter shared with others is considered "the client's member's home". A facility which meets the definition of a nursing facility, room and board, licensed residential care facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-899.1 et seq., and Section 1-1902 et seq., and/or in any other typed of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as considered the "the client's member's home" for delivery of Medicaid SoonerCare Personal Care Program services. Personal Care shall not be approved if the client lives in the PCA's home except with agreement of the interdisciplinary service planning team that this is consistent with plan goals and outcomes for the client and has Personal Care Program administrative approval, or, if an ADvantage client, AA administrative approval. These services are not intended to take the place of regular care by family and significant others. When there is an informal (not paid) system of care available in the home, Personal Care service provision will supplement the system within the limitations of policy.~~

(c) Personal Care services may be provided either by an individual employed by the member DHS qualified contractor who is referred to as a Personal Care Assistant (PCA) employed by the client or by an a qualified employee of a home care agency holding a valid certification and contract to provide Medicaid Personal Care service that is certified to provide PC services and contracted with the OHCA to provide PC services. OKDHS must determine a PCA to be qualified to provide PC services before they can provide services.

317:35-15-8. Agency Personal Care service management

(a) ~~The LTC At the time of assessment, the OKDHS nurse informs the client member of the Agency Personal Care service contractors qualified agencies in the their local area who are contracted available to deliver provide Personal Care services and obtains the client's informed member's primary and secondary choice of agencies. The client chooses a primary and secondary agency contractor from a list of qualified agencies. If the client and/or member or family declines to make a choice choose a primary PC service agency, the OKDHS nurse uses a rotating system to select selects an agency contractor from a list of all local certified provider available agencies, using a round-robin system. The LTC OKDHS nurse documents the name of the selected PC service agency.~~

(b) After medical and financial eligibility have ~~been~~ are established, the LTC nurse reviews the care plan and service plan with the client and contractor and notifies the client and agency contractor to begin care plan and service plan implementation. The nurse maintains the original plans and forwards a copy of the UCAT, the Personal Care Planning Schedule, the approved Personal Care plan and the service plan to the chosen agency contractor and client within one working day of notice of approval OKDHS contacts the member's preferred PC service agency or, if necessary, the

secondary agency or the agency selected by the rotation system. The OKDHS nurse forwards the referral to the PC services agency and establishes an initial PC skilled nursing service authorization for assessment and care plan development. Within one working day, OKDHS notifies the PC service agency and member of eligibility approval and also the authorization for PC skilled nursing for assessment and care plan development. The agency, prior to placing a PCA in the client's member's home, initiates an OSBI background check, checks the DHS OKDHS Community Services Worker Registry in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and, as appropriate, checks the Certified Nurse Aid Registry.

(c) The LTC nurse is the case manager and monitors the care plan and service plan for clients. The LTC nurse contacts the client within 30 calendar days of submitting the care plan and service plan to the agency in order to make sure that services have been implemented and the needs of the client are being met. The LTC nurse makes a home visit at a minimum of every 180 days beginning within 90 days of the date of service initiation for all individuals receiving Personal Care for the purpose of assessing the client's satisfaction with their care and for evaluating the plan of care for adequacy of goals and units allocated. Whenever a home visit is made, the LTC nurse communicates to the home health agency the results of the visit as documented on the Personal Care Services Progress Notes, DHS form AG-22. Requests by the agency for increases in the time allocated in the care plan and service plan are submitted to the LTC nurse and approved by the area nurse, or designee, prior to implementation. Within ten working days of receipt of the member's PC eligibility approval, the PC services agency skilled nurse completes an in-home assessment of the member's PC service needs, develops a care plan and submits the plan to the OKDHS nurse. The member's PC services care plan includes PC services goals and tasks, the number of authorized PC service units per month, frequency of PC service visits, the begin date for PC services, and the care plan end date which is no more than one year from the plan begin date. If more than one person in the household has been authorized to receive PC services, all household members' care plans are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of PC service authorized for each individual is distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.

(d) When the service provider returns the service plan with a start date, the LTC nurse or the AA notifies the county social worker in writing of the number of units and the start date of PC services. Within three working days of receipt of the care plan from the PC services agency, the OKDHS nurse reviews and approves or denies the care plan and notifies the agency. The OKDHS nurse may also reduce the number of units requested by the PC services agency and then approve the care plan. When the OKDHS nurse denies a plan or approves a plan with fewer authorized units than the submitted plan, OKDHS consults with the PC services agency prior to denying the care plan or approving the care plan with reduced units.

(e) Personal Care is provided under the State Plan if a client requires Personal Care and is approved for the ADvantage waiver. It is the ADvantage case manager's responsibility to develop and monitor the care plan and service plan. The ADvantage case manager reviews the service plan with the client and forwards a copy of the service plan to the agency. All requests by the agency for increases in the time allocated in the service plan are submitted to the case manager and must be approved by the AA, or designee, prior to implementation. The ADvantage case manager contacts the client monthly and makes a home visit at a minimum of every 90 days and the home care agency nurse makes a home visit at a minimum of every 180 days to evaluate the client. Case manager and home care agency nurse visits are for the purpose of surveying the client's satisfaction with their care and for evaluating the plan of care for adequacy of goals and units allocated. The ADvantage case manager contacts the client within 5 calendar days of service plan certification by the AA in order to make sure that services have been implemented. The ADvantage case manager contacts the client within 30 calendar days of service plan certification by the AA in order to make sure that the needs of the client are being met. Any person approved under the ADvantage waiver is eligible to receive any Medicaid service including those in the State Plan (Refer to OAC 317:35-17). Prior to placing a PC attendant in the member's home or other service-delivery setting, an OSBI background check, OKDHS Community Service Worker Registry check in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and as appropriate, the Certified Nurse Aide Registry Check must be completed.

(f) With the exception of clients served by the ADvantage or any other Home and Community Based Services (HCBS) Waiver, the LTC nurse is the case manager for Personal Care (PC) clients. Clients served by the ADvantage or any other HCBS Waiver have case management services provided through these waivers. This function involves advocacy, service planning, coordination, monitoring and problem solving with service providers and with families in the provision of services. The PC service skilled nurse monitors their member's care plan. The PC service provider agency contacts the member within 5 calendar days of receipt of the approved care plan in order to make sure that services have been implemented and the needs of the member are being met. The PC services agency nurse makes a home visit at least every 180 days to assess the member's satisfaction with their care and to evaluate the care plan for adequacy of goals and units authorized. Whenever a home visit is made, the PC services agency nurse documents their findings in the personal care services progress notes. Requests by the PC service agency to change the number of units authorized in the care plan are submitted to OKDHS and are approved or denied by the OKDHS area nurse, or designee prior to implementation of the changed number of units. Annually, or more frequently if the member's needs change, the PC services agency nurse re-assesses member's need and develops a new care plan to meet personal care needs. If the member's need does not change, the agency nurse may re-authorize the member's existing plan.

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(g) ~~Since PC services are intended to supplement and support existing informal care, use of informal supports as PCAs may jeopardize the informal support system [see OAC 317:35-15-2(a)]. The provider agency may only employ informal supports with the written agreement of the interdisciplinary team. When the PC services agency returns the member's care plan containing a service start date to OKDHS, the OKDHS nurse notifies the OKDHS county social worker in writing of the service and number of authorized PC service units and the start and end date of PC service authorization.~~

317:35-15-8.1. Agency Personal Care contractors services; billing, and problem issue resolution

~~The Administrative Agent (AA) certifies qualified PC service agencies and facilitates the execution of the agencies' SoonerCare contracts on behalf of OHCA with qualified agencies for provision of Personal Care services. At contract renewal, the AA re-evaluates provider qualifications and facilitates execution of renewal contracts on behalf of the OHCA. OHCA will check the list of providers that have been barred from Medicare/Medicaid participation to ensure that the provider PC services agency is not listed.~~

(1) **Payment for Personal Care.** ~~Payment for Personal Care PC services is generally made for care in the client's member's "own home". A In addition to an owned or rented home, a rented apartment, room or shelter shared with others is considered to be the member's "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., does not constitute a suitable substitute home and/or in any other type of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as the member's "own home" for delivery of PC services through SoonerCare. Personal Care may not be approved if the client lives in the PCA's home except with the interdisciplinary team's written approval. With OKDHS area nurse prior approval, or for ADvantage waiver clients, with service plan authorization and ADvantage Program Manager approval, Personal Care PC services may be provided in an educational or employment setting to assist the client member in achieving vocational goals identified on the service care plan.~~

(A) **Use of Personal Care service agency—contractors for Personal Care.** ~~To provide Personal Care PC services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by OKDHS or the Administrative Agent (AA), and possess a current Medicaid SoonerCare contract.~~

(B) **Reimbursement.** ~~Personal Care services payment for on behalf of a client member is made according to the type of service and number of units~~

~~of service PC services identified authorized in the service care plan.~~

(i) ~~The unit amounts amount paid to agency contractors PC services providers for each unit of service is according to the established SoonerCare rates for the PC services. A service plan will be developed for each eligible individual in the home and units of service assigned to meet the needs of each client. The service plans will combine units in the most efficient manner to meet the needs of all eligible persons in the household. Only authorized units contained on each eligible member's individual care plan are eligible for reimbursement. Providers serving more than one PC service member residing in the same residence will assure that the members' care plans combine units in the most efficient manner possible to meet the needs of all eligible persons in the residence.~~

(ii) ~~The contractor payment fee covers all Personal Care services included on the service and care plans developed by the LTC nurse or ADvantage case manager. Payment for PC services is for tasks performed in accordance with OAC 317:30-5-951 only when listed on an authorized care plan. Payment is made for direct services and care of the eligible client(s) only. The area nurse, or designee, authorizes the number of units of service the client receives each month for PC skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per assessment/service planning visit by the provider agency personal care skilled nurse.~~

(2) **Problem Issue resolution.** ~~If the client member is dissatisfied with the PC services provider agency or the assigned PCA, and has exhausted attempts to work with the PC services agency's grievance process without resolution, the client contacts the LTC member may contact the OKDHS nurse for problem resolution to attempt to resolve the issues. If the situation cannot be resolved, the The client member has the right to appeal to the OHCA in accordance with OAC 317:2-1-2. (Refer to OAC 317:2-1-2). For clients—members receiving ADvantage services, the member or family should contact their case manager should be contacted for the problem resolution. If the problem remains unresolved, the contact member or family should contact may be made with the Consumer Inquiry System (CIS) at the Long Term Care Authority. Providers are required to provide the CIS contact number to every member. The ADvantage Program member also has the right to appeal to the OHCA in accordance with OAC 317:2.~~

317:35-15-10. Redetermination for Personal Care services

(a) **Recertification.** ~~The LTC OKDHS nurse re-assesses the PC services client member for medical re-certification based on the member's needs and level or caregiver support required, using the UCAT at least every 36 months. The LTC~~

nurse, with the client's input, prepares a new care plan and service plan with any required adjustments in service. During this re-certification assessment, the OKDHS nurse informs the member of the state's other SoonerCare long-term care options. The LTC OKDHS nurse submits the re-assessment, ~~new care plan, and new service plan~~ to the OKDHS area nurse, or designee, for re-certification and authorization of services at a maximum of every 36 months. Recertification documents are sent to the area nurse, or designee, by no later than the tenth day of the month in which the certification expires. When the area nurse, or designee determines medical eligibility for Personal Care PC services, a service plan and care plan re-certification review date is entered on the system. The care plan and service plan re-certification depends on the client's needs and on the adequacy of the client's caregiver support.

(b) **Change in level of care.** If it comes to the attention of the LTC nurse that there is a marked change in an individual's condition that may affect medical eligibility or level of care, the nurse and social worker discuss the change to determine a plan of action. The LTC nurse discusses the plans with the client and contractor. If a client in a nursing facility is planning to return home, requests personal care and has a current medical evaluation review date, another medical decision is necessary. If there is not a current medical review date and the client requests a change in level of care, the UCAT, care plan and service plan are completed and sent to the area nurse, or designee, for a medical decision.

(e b) **Change in service plan and care plan for State Plan PC members.** Upon notification by the PC service agency of the member's need for a change in the amount of PC service required, the OKDHS nurse initiates the process to increase or decrease the approved units of service on the member's care plan. Based on the documentation provided by the PC service agency to OKDHS, the area nurse or designee approves or denies the care plan changes within three working days of receipt of the request. A copy of the signed care plan is included in the case record. The social worker updates the service authorization system after they are notified of the increase or decrease.

(1) **Non-ADvantage clients.** The service contractor or the LTC nurse initiates the process for an increase or decrease in units of service to the client's service and care plans using a service provider communication form, DHS form AG 7. Requested changes in service and justification for changes must be documented on the form. The area nurse, or designee, approves or denies the service plan and care plan change within three working days of receipt of the plan. A copy of the signed service plan is included in the case record. A significant change in the client's physical condition or caregiver support that requires an increase in service of 18 hours per month, either wholly or incrementally during the medical certification period, requires a UCAT re-assessment by the LTC nurse. Based on the re-assessment, the client may, as appropriate, be certified for a new care plan and service plan, certified for a different level of care or be eligible for a different service program. The LTC nurse notifies the social worker of an increase or decrease in services once approval is received in order that the authorization system can be updated.

(2) **ADvantage clients.** The service contractor or the ADvantage case manager initiates the process for an increase or decrease in units of service to the client's service plan using a service provider communication form. Requested changes in service and justification for changes must be documented on the form. The AA, or designee, approves or denies the service plan change within three working days of receipt of the plan. When the AA authorizes an increase in the number of units of service, the AA notifies the county social worker for entry into the authorization file effective the date the hours increased. When the AA authorizes a decrease in the number of units of service, the AA notifies the county social worker for entry into the authorization file effective the first of the next month. If received after the computer change deadline, the change will be effective the first of the following month. A copy of the certified service plan addendum is included in the case record by the AA. The AA notifies the social worker of an increase or decrease in services in order that the authorization system can be updated.

(d c) **Voluntary closure of Personal Care State Plan PC services.** If the a client member decides Personal Care services is are no longer needed to meet his/her needs, a medical decision from the area nurse, or designee, is not needed. The client member and the LTC OKDHS nurse or social worker completes and signs DHS OKDHS form AG-17, Voluntary Action of Personal Care Case Closure form.

(e d) **Resuming Personal Care State Plan PC services.** If a client member approved for Personal Care services has been without PC services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved care plan and service plan but still has a current PC services medical and SoonerCare financial eligibility approval, PC services may be resumed using the member's previously approved care plan. The PC service agency submits a PC services skilled nursing re-assessment of need within ten working days of the resumed plan start date. If the member's needs dictate, the PC services agency may submit a request for a change in authorized PC services units with the re-assessment for authorization review by OKDHS.

(f e) **Financial ineligibility.** Anytime the local office OKDHS determines a PC services client member does not meet the SoonerCare financial eligibility criteria, the local OKDHS office notifies the client member, contractor PC service provider, and the LTC OKDHS nurse of financial ineligibility. A medical eligibility redetermination is not required when the period of financial ineligibility does not exceed 90 days during the medical certification.

(g f) **Closure due to medical ineligibility.** Any time If the local OKDHS office is notified through the system of a decision that the a client member is no longer medically eligible for Personal Care, the social worker notifies the client member of the decision. The OKDHS nurse is responsible for notifying the contractor notifies the PC service agency.

(h g) **Termination of State Plan Personal Care Services.** The process for termination of Personal Care is provided in this subsection.

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(1) Personal Care services may be ~~terminated~~ discontinued if:

(A) the client member poses a threat to self or others as supported by professional documentation; or

(B) other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the client member or other household visitors; or

(C) the client member or family member fails to cooperate with Personal Care service delivery or to comply with OHCA or ~~DHS~~ OKDHS rules as supported by professional documentation; or

(D) the client's member's health, or safety, and well-being is at risk as documented on the UCAT; or

(E) additional services, either "formal" (i.e., paid by Medicaid or some other funding source) or "informal" (i.e., unpaid) are provided in the home eliminating the need for Medicaid SoonerCare Personal Care services.

(2) ~~Personal Care services will be terminated when the~~ The client member refuses to select and/or accept the services of ~~an a~~ PC service agency or PCA for 90 consecutive days as supported by professional documentation.

(3) ~~The LTC nurse~~ For persons receiving State Plan PC services, the PC services agency submits documentation with the recommendation to the area nurse for a medical decision ~~discontinue services to OKDHS~~. The ~~DHS Aging Services Division~~ OKDHS notifies the client member and the Personal Care service agency or PCA, area nurse, LTC nurse and the local county social worker of the decision to terminate services. The social worker is ~~responsible for updating the computer system, closing~~ closes the authorization on the OKDHS system and sending which sends an official closure notice to the client with the member informing them of their appropriate client member rights to appeal the decision to discontinue services.

317:35-15-13.1. Individual Personal Care service management

(a) An individual PCA may be authorized utilized to provide PC services when it is documented to be in the best interest of the client member to have an individual personal care attendant (PCA) or when there are no agency contractors qualified PC service agencies available in the member's local area. When an individual PCA is selected utilized by the client, the ~~DHS~~ OKDHS nurse explains OHCA form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, to the client member and obtains his/her signature. OHCA will check the list of providers that have been barred from Medicare/Medicaid participation to ensure that the individual provider is not listed.

(b) After ~~medical and financial eligibility have been~~ PC services eligibility is established and prior to implementation of PC services using an individual PAC, the ~~LTC~~ OKDHS nurse reviews the care plan and ~~service plan~~ with the client member and individual PCA and notifies the client member and PCA to begin ~~care plan and service plan implementation~~ PC services delivery. The OKDHS nurse maintains the original plans care

plan and forwards a copy of the approved ~~Personal Care~~ care plan and service plan to the chosen PCA within one working day of notice of approval.

(c) The ~~LTC~~ OKDHS nurse is the ~~case manager~~ and monitors the care plan and ~~service plan~~ for clients members with an individual PCA. ~~The LTC nurse makes a home visit at a minimum of every 180 days beginning within 90 days of the date of service initiation for all individuals receiving Personal Care for the purpose of surveying the client's satisfaction with their care and for evaluating the plan of care for adequacy of goals and units allocated. Requests for increases in the time allocated in the care plan and service plan are submitted to the LTC nurse and approved by the area nurse, or designee, prior to implementation. For any member receiving PC services utilizing an individual PCA, the OKDHS nurse makes a home visit at least every 180 days beginning within 90 days of the date of PC service initiation. OKDHS assesses the member's satisfaction with their PC services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan must be approved by the OKDHS area nurse, or designee, prior to implementation of the changed number of units.~~

(d) ~~Personal Care is provided under the State Plan if a client requires Personal Care and is approved for the ADvantage waiver. It is the ADvantage case manager's responsibility to develop and monitor the care plan and service plan. If a member requires an individual PCA and is also approved for ADvantage waiver, the ADvantage case manager develops and monitors PC service delivery as part of the ADvantage service plan. The ADvantage case manager reviews the service care plan with the client member and forwards a copy of the service plan to the individual PCA. The ADvantage case manager contacts the member within five calendar days of service plan certification by the AA in order to make sure that services have been implemented. The ADvantage case manager contacts the member within 30 calendar days of service plan certification by the AA in order to make sure the needs of the member are being met. Requests for increases changes in the time allocated in the service plan authorized PC services units are submitted to the case manager and must be approved by the AA, or designee, prior to implementation by the ADvantage case manager for approval or denial by the AA or designee, prior to implementation of the changes in units. The ADvantage case manager contacts the client member monthly and makes a home visit at a minimum of least every 90 days and the LTC nurse makes a home visit at a minimum of every 180 days for supervision to evaluate the care plan for adequacy of goals and units allocated. Case manager and LTC nurse visits are for the purpose of assessing the client's satisfaction with their care and for evaluating the plan of care for adequacy of goals and units allocated. The ADvantage case manager contacts the client within 5 calendar days of service plan certification by the AA in order to make sure that services have been implemented. The ADvantage case manager contacts the client within 30 calendar days of service plan certification by the AA in order to make sure that the needs of the client are being met. Any person approved under the~~

ADvantage waiver is eligible to receive any Medicaid service including those in the State Plan (Refer to OAC 317:35-17).

(e) With the exception of clients members served by the ADvantage or any other Home and Community Based Services (HCBS) Waiver, the LTC OKDHS nurse is the case manager for Personal Care (PC) clients responsible for assessing and monitoring the provision of personal care for Individual Personal Care members. ~~Clients served by the ADvantage or any other HCBS Waiver have case management services provided through these waivers.~~ This function involves advocacy, service planning, coordination, monitoring and problem solving with service providers and with families in the provision of services.

(f) ~~Since PC services are intended to supplement and support existing informal care, use of informal supports as PCAs may jeopardize the informal support system [see OAC 317:35-15-2(a)].~~ Under certain circumstances, the use of informal supports as individual PCAs may be the only available option for providing services to the client member. The ADvantage Program consumer's interdisciplinary team authorizes the use of informal supports for the PC program.

(1) ~~One or more of the following conditions as determined by the LTC nurse must exist in order for informal supports to be approved as PCA service providers:~~

(A) ~~The informal support is the only person who has the special ability and willingness to provide care due to the complexity of care needed; or,~~

(B) ~~The client lives in a remote, rural area that has no personal care providers; or~~

(C) ~~No other persons are available to provide PCA services in the community where the client lives.~~

(2) ~~The interdisciplinary team provides written justification on the plan of care for use of a family member as the PCA.~~

(3) ~~Whenever informal supports provide PCA services, care plan and service plan development must include components to prevent failure/burnout of the informal supports and assurances that the client is receiving the care required.~~

(A) Components built into the care plan to prevent failure/burnout of informal supports may include, but are not limited to, the following:

(A) an utilization of additional informal support supports, other than the one providing PCA services, provides services; and

(B) provision of home-delivered meals, adult day care, or formal PCA PC services by an agency are provided.

(B) The ADvantage Program case manager routinely reviews the care plan to evaluate whether ensure the services authorized meet the client's member's needs are being met in accordance with the plan and to assess the stability of the informal support system and to assess the stability of the informal support system. The For members who receive services from an individual PCA, the case manager may increase the frequency of care plan

~~these reviews for clients receiving PCA services from an informal support.~~

[OAR Docket #07-695; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**

[OAR Docket #07-705]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 21. Breast and Cervical Cancer Treatment Program
317:35-21-12 [AMENDED]
(Reference APA WF # 06-21)

AUTHORITY:
Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

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INCORPORATIONS BY REFERENCE:
N/A

ANALYSIS:
Agency rules are revised to establish specific time frames, following approval for the Breast and Cervical Cancer Treatment program (BCC), in which a member has to seek diagnostic testing and treatment for breast and cervical cancer. Currently, there is no specific time frame for a member to complete diagnostic testing for BCC. Once a member has an abnormal screening for breast and/or cervical cancer and meets eligibility requirements, they are certified for full scope Medicaid benefits. The member maintains full scope of benefits until their diagnostic testing is completed and results are reviewed by OHCA Care Managers to determine if the member is still in need of treatment. There have been circumstances in which a member purposefully delays diagnostic testing while they focus on other personal medical concerns. More commonly, the member does not place high priority on completing their testing and therefore the case will remain open for extended periods of time

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while the member seeks no care at all. Additionally, some members have no intention of seeking treatment. Under the current policy, OHCA has no recourse to close the case upon the members decision to not seek treatment. The proposed revisions would enable the case to be closed if the member does not seek treatment within the 60 day time frame or if the member refuses treatment.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 21. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

317:35-21-12. Changes after certification/continued need for treatment

(a) A woman found to be in need of treatment as the result of an abnormal BCC screen ~~receives~~ has 60 days from the date of the application to complete the initial appointment for a diagnostic testing procedure and an additional 60 days to complete any additional diagnostic testing required or to initiate compensable treatment for a cancerous or pre-cancerous condition. The exception to the time limit is evidence of a lack of appointment availability to determine if she has breast and/or cervical cancer. Upon completion of the diagnostic testing, OHCA is provided a medical report of the findings.

~~(1) When diagnostic testing is complete, the OKDHS is notified if~~ If the woman was is found not to have BCC breast or cervical cancer including pre-cancerous conditions and early stage, recurrent or metastatic cancer. When the woman is found not to have breast or cervical cancer, the case is closed by OKDHS and appropriate notification is computer generated. for which she is in need of treatment or fails to have diagnostic testing or begin treatment within the time frames described in OAC 317:35-21-12(a), the case is closed by OKDHS and appropriate notification is computer generated.

~~(2) If a medical report necessary to determine continued treatment is not received from a provider within ten working days after a request is made by OHCA, the report is considered negative and the case is closed by OKDHS and appropriate notification is computer generated.~~

~~(b) If it is determined at any time during the certification period that the woman has creditable health insurance coverage, the OKDHS worker closes the case and appropriate notification is computer generated~~ the woman in need of treatment refuses SoonerCare compensable treatment or diagnostic services and does not plan to pursue the care in the time frames described in OAC 317:35-21-12(a), the case is closed by OKDHS and appropriate notification is computer generated.

~~(c) If it is determined at any time during the certification period that the woman is no longer in need of treatment, the OKDHS worker closes the case and appropriate notification is computer generated.~~ In the event a woman is unable to initiate

or complete diagnostic services due to a catastrophic illness or injury occurring after certification, SoonerCare will remain open with the approval of a SoonerCare Medical Director or his/her designee.

~~(d) If the OKDHS worker later determines that the woman is otherwise eligible for Medicaid, the worker takes necessary actions to certify her for the appropriate category of Medicaid coverage~~ it is determined at any time during the certification period that the woman is no longer in need of treatment, the OKDHS worker closes the case and appropriate notification is computer generated.

~~(e) If it is determined at any time during the certification period that the woman has creditable health insurance coverage, the OKDHS worker closes the case and appropriate notification is computer generated.~~

~~(f) If the OKDHS worker later determines that the woman is otherwise eligible for SoonerCare, the worker takes necessary actions to certify her for the appropriate category of SoonerCare coverage.~~

[OAR Docket #07-705; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

[OAR Docket #07-709]

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PERMANENT final adoption

RULES:

Subchapter 5. Client Services

~~Part 1. Companion/Adult Foster Care Services by Agency Companion Services~~

317:40-5-3 [AMENDED]

Part 11. Community Residential Supports

317:40-5-152 [AMENDED]

Subchapter 7. Waiver Employment Services

317:40-7-8 [AMENDED]

317:40-7-18 [AMENDED]

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ANALYSIS:

Developmental Disabilities Services rules are revised to facilitate consistency with Medicaid provider requirements, comply with current practices and procedures and laws governing such, delete unnecessary language, and update referenced policy cites. The proposed revisions are required to clarify DDSD Home and Community-Based Services Waiver program provisions as well as habilitation services. Rules regarding agency companion services are revised to delineate levels of support criteria. Group home rules are revised to reflect current provisions and requirements. Rules are further revised to provide contracting guidelines for HCBS Waiver employment services.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. CLIENT SERVICES

PART 1. COMPANION/ADULT FOSTER CARE SERVICES BY AGENCY COMPANION SERVICES

317:40-5-3. ~~Scope of Agency Companion Services~~ agency companion services

(a) ~~Agency Companion—Services~~ companion services (ACS):

- (1) ~~are provided through by private agencies that have current—contracts~~ contracted with the Oklahoma Health Care Authority (OHCA);
- (2) are available to members who are eligible for services through the Community Waiver or Homeward Bound Waiver;
- (3) are based on the member's need for support as described in the member's Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58;
- (4) are provided in a nurturing environment in the member's home, the companion's home, or in a mutually rented or owned home; and
- (5) support visitation desired by the member with his or her natural family and friends, and in accordance with the member's IP.

(b) ~~Persons desiring to be companions are~~ An agency companion:

- (1) must be employed by or contract with a provider agency and are approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services. ;

(2) is limited to serving as companion for one member; exceptions may be granted only upon review by the DDSD director or designee;

(3) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5-5.

(A) Employment as an agency companion is the companion's primary employment.

(B) The companion may have other employment when:

(i) servicing members approved for intermittent or regular levels of support;

(ii) the Personal Support Team addresses all documented related concerns in the member's IP; and

(iii) the other employment is approved in advance by the DDSD area manager or designee; and

(4) approved for other employment may not be employed in another position that required on-call duties.

(A) If, after receiving approval for other employment, authorized DDSD staff determines the other employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 days:

(i) the other employment; or

(ii) his or her employment as an agency companion.

(B) Homemaker, habilitation training specialist, and respite services are not provided in order for the companion to perform other employment.

(e) ~~The service recipient receives ACS in his or her own home, the companion's home, or in a mutually rented or owned home.~~

(d) ~~Services are based on the service recipient's need for support as described in the Individual Plan detailed in OAC 340:100-5-50 through 100-5-58, and are available to individuals eligible for services through the Community Waiver or the Homeward Bound Waiver.~~

(e) ~~Services provide the service recipient with a nurturing home environment.~~

(f) ~~Services support visitation desired by the service recipient with his or her natural family and friends.~~

(g) ~~Each service recipient member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's salary.~~

(1) Therapeutic leave:

(A) is a Medicaid payment made to the contract provider to enable the service recipient member to retain services; ; and

(B) Therapeutic leave is claimed when:

(i) the service recipient member does not receive ACS for 24 consecutive hours because of due to:

(A) a visit with family or friends without the companion;

(B) vacation without the companion; or

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- (C) hospitalization, whether the companion is present or not; or
- (ii) the companion uses authorized relief time;
- (2C) An individual may receive therapeutic leave for is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year; and
- (D) cannot be accrued from one Plan of Care year to the next;
- (32) The payment for a day of therapeutic leave daily rate is the same amount as the ACS per diem rate for ACS.
- (43) The provider agency pays to the agency companion the salary that he or she would have earned if earns when the service recipient were member is not on therapeutic leave.
- (5) Therapeutic leave cannot be accrued from one Plan of Care year to the next.
- (h) The companion may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the service recipient, as listed in OAC 317:40-5-5.
- (1) Serving as the service recipient's companion is the companion's primary employment.
- (2) The companion may have other employment when:
- (A) the Team has documented in the Individual Plan their efforts to address possible related concerns; and
- (B) the other employment has been approved in advance by the DDS area manager or designee.
- (3) No companion can have a job that requires on-call duties.
- (4) If, after receiving approval for other employment, authorized DDS staff determine that the employment interferes with the care, training, or supervision needed by the service recipient, the companion must determine if he or she wants to terminate the other employment or terminate his or her employment as an agency companion.
- (5) Homemaker, Habilitation Training Specialist, and Respite Services are not provided in order for the companion to perform other employment.
- (i d) The level Levels of support is for the member and corresponding payment are:
- (1) determined by authorized DDS staff in accordance with this subsection levels described in (A) through (C); and
- (2) re-evaluated when the member has a change in agency companion providers.
- (+ A) **Intermittent level of support.** Intermittent level of support is described in this paragraph.
- (A) The authorized when the service recipient is able to perform basic daily living skills such as member:
- (i) requires minimal assistance with basic daily living skills, such as bathing, dressing, and eating;
- (ii) independent toileting;
- (iii) basic survival skills; and
- (iv) awareness of danger to self and others.
- (ii) communicates needs and wants;
- (iii) is able to spend short periods of time unsupervised inside and outside the home;
- (iv) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments or other activities, and arranging transportation; and
- (v) has stable or no ongoing medical or behavioral difficulties.
- (B) The companion:
- (i) assists the service recipient in:
- (I) money management;
- (II) accessing and participating in generic services such as transportation, and recreational opportunities; and
- (ii) may provide limited assistance in such areas as:
- (I) daily living skills;
- (II) medication administration; and
- (III) instrumental activities of daily living such as shopping, cleaning, and preparing meals.
- (C) The companion assists the service recipient in establishing long term relationships.
- (2B) **Regular level of support.** Regular level of support is described in this paragraph. authorized when the member:
- (A i) The companion is responsible for requires regular, frequent and sometimes constant supervision assistance and support to assist the service recipient in participation in or is totally dependent on others to complete daily living skills, leisure activities, and personal relationships. such as bathing, dressing, eating, and toileting;
- (ii) has difficulty or is unable to communicate basic needs and wants;
- (iii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments or other activities, and arranging transportation; and
- (iv) requires regular monitoring and assistance with health, medication, or behavior interventions, and may include the need for specialized training, equipment, and diet.
- (B) The companion is trained and competent to meet the service recipient's needs which may include behavioral or medical occurrences requiring increased supports for limited periods of time.
- (C) The companion is trained and competent to provide supports for a service recipient who receives medication for altering behavior. When the service recipient's record documents no more than episodic behavioral occurrences, the companion receives the regular support level of pay.

~~(D) The companion ensures the service recipient has on going daily supervision in a stable environment.~~

~~(3C) Enhanced level of support. Enhanced level of support is described in this paragraph. authorized when the member:~~

- ~~(i) is totally dependent on others for:

 - ~~(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and~~
 - ~~(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments or other activities, and arranging transportation;~~~~
- ~~(ii) demonstrates ongoing complex medical or behavioral issues requiring specialized training courses per OAC 340:100-3-38.3; and~~
- ~~(iii) has medical support needs that are rated at Level 4, 5, or 6 on the Physical Status Review (PSR), per OAC 340:100-5-26. In cases where complex medical needs are not adequately characterized by the PSR, exceptions may be granted only upon review by the DDS/D director or designee; or~~
- ~~(iv) requires a Protective Intervention Plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must be:

 - ~~(I) approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14; and~~
 - ~~(II) reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6.~~~~

~~(A) The companion is highly skilled and competent to meet the service recipient's needs that include on going complex medical or behavioral situations that require the highest level of supports and companion expertise.~~

~~(B) The companion receives extensive specialized training in order to meet the complex needs of the service recipient. The companion demonstrates the competency to meet the integral needs of the service recipient.~~

~~(C) The provider of services at the enhanced rate may not have other employment.~~

PART 11. COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-152. Group home services for persons with mental retardation or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to 24-hour per day supervision, supportive assistance, and training in daily living skills to persons who are eligible individuals eighteen 18 years of age and or older. Upon approval of the ~~director of the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) of~~

~~the Oklahoma Department of Human Services director or designee, persons younger than eighteen 18 may be served.~~

~~(1) Group homes ensure that persons residents reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.~~

~~(2) Group homes must be licensed by DDS/D in accordance with 10 O.S. § Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.~~

~~(3) Persons receiving Residents of group home services homes receive no other form of residential supports.~~

~~(4) Habilitation training specialist (HTS) services or Homemaker homemaker services for persons receiving residents of group home services homes may be approved only by the DDSD director of DDS/D or designee to resolve a temporary emergency when no other resolution exists.~~

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide DDSD Home and Community-Based Waiver Services (HCBS) Waiver for the Mentally Retarded persons with mental retardation or related conditions.

(1) Group home providers must have a completed and approved Application for Provider Agency from DDSD application to provide DDSD group home services.

- (2) Provider's Group home staff must:
 - (A) complete the OKDHS DDSD-sanctioned training curriculum in accordance with per OAC 340:100-3-38; and
 - (B) fulfill requirements for pre-employment screening given at per OAC 340:100-3-39.

(c) **Description of services.**

~~(1) Group home services; are provided in accordance with this subsection.~~

~~(A) meet all applicable requirements of OAC 340:100; and~~

~~(+ B) Services to each individual are provided in accordance with the each resident's Individual Plan (IP) developed in accordance with per OAC 340:100-5-50 through 400-5-54 100-5-58.~~

~~(2i) Health care services are secured in accordance with for each resident per OAC 340:100-5-26.~~

~~(ii) Residents are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.~~

~~(32) Group homes home providers:~~

~~(A) follow protective intervention practices described in per OAC 340:100-5-57 and 340:100-5-58.~~

~~;~~

~~(4) Individuals are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.~~

~~(5) Group home services meet all applicable requirements of OAC 340:100.~~

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(6B) ~~In~~ in addition to the documentation required by per OAC 340:100-3-40, the provider agency must maintain:

(A) ~~i~~ i staff time sheets ~~which~~ that document the hours each staff member was present and on duty in the group home; and

(B) ~~ii~~ ii documentation of each ~~service recipient's~~ resident's presence or absence on the daily attendance form provided by DDS; ~~;~~ and

(7C) ~~The provider agency ensures that ensure~~ program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services per OAC 340:100-5-22.6 and 340:100-6, as applicable.

(A) ~~The PCS must:~~

(i) ~~get to know each person receiving services and his or her needs;~~

(ii) ~~make announced and unannounced visits to the group home. The PCS makes a minimum of three unannounced monitoring visits per month. Of the unannounced visits:~~

(I) ~~at least one unannounced visit each month must occur on Saturday or Sunday; and~~

(II) ~~another must occur between 8:00 p.m. and 7:00 a.m. on a weekday;~~

(iii) ~~provide support and assistance to any person receiving services who is experiencing an emotional, behavioral, or medical crisis;~~

(iv) ~~be accessible to direct service staff 24 hours per day and available to respond, in person if necessary, to an emergency;~~

(v) ~~supervise direct contact staff to promote achievement of outcomes in the Plan;~~

(vi) ~~assist the case manager as requested to prepare for and implement the Plan and its revisions in accordance with OAC 340:100-5-50 through 340:100-5-58;~~

(vii) ~~ensure rules of OKDHS and OHCA are followed; and~~

(viii) ~~complete necessary training as specified in OAC 340:100-3-38.~~

(B) ~~Each person filling this role in a provider agency must have a minimum of four years of any combination of college level education and full time equivalent experience in serving persons with disabilities, unless this requirement is waived in writing by the DDS director or designee.~~

(8) ~~Staff who assist an individual with bathing or showering have the responsibility to ensure the water temperature is safe and comfortable for the individual being bathed. The requirements of this paragraph are enforced even if an anti-scald device is in use.~~

(d) **Coverage limitations.** Services Group home services are provided up to 366 days per year.

(e) **Types of group home services.** There are three types of group home services provided through Home and Community-Based Waiver Services HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than 12 ~~persons~~ residents per OAC 340:100-6.

(A) ~~Homes opened after the effective date of these rules serve no more than six individuals.~~

(B) ~~Traditional group home services may also be provided through DDS state funds.~~

(2) **Community living homes.** Community living homes serve ~~up to six individuals~~ no more than 12 residents.

(A) ~~Persons~~ Residents who receive community living home services have:

(i) ~~needs that cannot be met in a less structured setting; ; and These include people with:~~

(i) ~~ii~~ ii a diagnosis of severe or profound mental retardation requiring frequent assistance in the performance of activities necessary for daily living or continual supervision to ensure the ~~individual's~~ resident's health and safety; or

(ii) ~~iii~~ iii complex needs requiring frequent:

(I) ~~assistance in the performance of activities necessary for daily living, such as the frequent assistance of staff for positioning, bathing, or other necessary movement; or~~

(II) ~~complex needs requiring frequent supervision and training in appropriate social and interactive skills in order to remain included in the community.~~

(B) Services offered in a community living home include:

(i) ~~24-hour awake supervision~~ when a resident's IP indicates it is necessary; and

(ii) ~~program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.~~

(3) **Alternative group homes.** Alternative group homes serve ~~up to no more than four individuals~~ residents who have evidence of behavioral or emotional challenges in addition to mental retardation and require extensive supervision and assistance in order to remain in the community.

(A) ~~To be eligible for~~ Residents who receive alternative group homes home services ~~an individual~~ must meet criteria ~~given per~~ in OAC 340:100-5-22.6.

(B) ~~Services are provided in accordance with OAC 340:100-5-22.6 to meet the needs of the service recipient including:~~

(i) ~~supports to assist the service recipient in acquiring, retaining, and improving self care, daily living, social, adaptive, and leisure skills needed to reside successfully within the community;~~

(ii) ~~24-hour awake staff;~~

(iii) ~~specialized training developed to meet the specific needs of each service recipient; and~~

- (iv) ~~program supervision and oversight including 24 hour availability of response staff to meet individual schedules or unpredictable needs.~~
- (~~C~~B) ~~A determination must be made by the Developmental Disabilities Services Division DDSD Community Services Unit that the alternative group home is services are appropriate and all other community residential services are not appropriate.~~

SUBCHAPTER 7. WAIVER EMPLOYMENT SERVICES

317:40-7-8. Employment Training Specialist Services training specialist services

Employment Training Specialist training specialist (ETS) Services may be used as described in this Section.

(1) Employment Training Specialist Services services include evaluation, training, and supportive assistance that allow the member to obtain and engage in remunerative employment. ETS services are:

(A 1) ~~must~~ be provided by a certified Job Coach job coach; and

(B 2) ~~are~~ not available when subcontracting; ;

(2) Employment Training Specialist Services may be used for:

(A) training of service recipients employed in individual placements or two service recipients on the same job site on new jobs when the service recipient(s) receives at least minimum wage and the employer is not the employment services provider;

(~~3~~ 3) ETS is used to help a service recipient member with a new job in a generic employment setting.

(A) ETS is services are:

(i) not available if the service recipient member held the same job for the same employer in the past; ;

(ii) ETS is available when the member requires 100% on-site intervention for up to the number of hours the service recipient member works per week for six weeks in each per Plan of Care year; as long as the job coach provides 100% on site intervention. ; and

(iii) used in training members employed in individual placements on new jobs when the:

(I) member receives at least minimum wage; and

(II) employer is not the employment services provider.

(iii B) If the service recipient member does not use all of the training units on the first job placement in the Plan of Care year, the balance of the training units may be used on a subsequent job placement with the current provider, or with a new provider; ;

(B 4) used in assessment and outcome development for service recipients members residing in the community who are new to the provider agency; , when determined necessary by the Personal Support Team (Team).

(~~4~~) The provider;

(A) may claim a documented maximum of 20 hours per service recipient member for initial assessment. The projected units for the assessment and outcome development must:

(i) be approved in advance by the Team; and

(ii) relate to the service recipient's member's desired outcomes; ; and

(B) cannot claim the same period of time for more than one type of service;

(ii) ~~If a service recipient changes agencies within the Plan of Care year, an additional 20 hours may be prescribed for assessment when determined necessary by the Team.~~

(iii) ~~A provider cannot claim the same period of time for more than one type of service.~~

(~~C~~ 5) used in Team meetings, when the case manager has requested participation of direct service employment staff in accordance with OAC 340:100-5-52, up to 20 hours per Plan of Care year;

(~~D~~ 6) used in job development for a service recipient member on a ~~one person or two person~~ an individual job site upon the service recipient's member's completion of three consecutive months on the job.

(A) Up to 40 hours may be used during a Plan of Care year after documentation of job development activities has been is submitted to the case manager.

(B) If the job site involves two service recipients, the job development units are claimed against one service recipient's Plan of Care or shared between the two service recipients' Plans of Care. The job(s) job must:

(i) pay at least minimum wage;

(ii) employ each service recipient member at least 15 hours per week; and

(iii) be provided by an employer who is not the service recipient's member's contract provider;

(~~E~~ 7) used in development of a Plan for Achieving Self-Support (PASS) up to 40 hours per Plan of Care year after documentation of PASS development, if not developed by an Oklahoma Benefit Specialist or the Department of Rehabilitation Services, and implementation of an approved PASS after documentation has been submitted to the case manager;

(~~F~~ 8) used in development of an Impairment Related Work Expense (IRWE) up to 20 hours per Plan of Care year after documentation of IRWE development, if not developed by an Oklahoma Benefit Specialist or Oklahoma Department of Rehabilitation, and implementation of an approved IRWE after documentation has been is submitted to the case manager; and

(~~G~~ 9) used in interviewing for a job that is eligible for ETS services.

317:40-7-18. Contracts with industry

(a) ~~Either The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) or a vocational provider may contract or subcontract~~

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with an industry or with an individual employed by the industry to provide Job Coaching Services to eligible DDS consumers job coaching services through a Natural Supports Initiative. The employer: -

(1) designates an existing employee to serve as job coach.

(A) The job coach completes training as approved by the DDS director of Human Resource Development.

(B) Training and support are available for members on the job; and

(2) is reimbursed at the individual placement in job coaching rate based on the hours the member works for the first six months.

(A) After the first six months of employment, the employer is reimbursed at the stabilization rate based on the hours the member works.

(B) Stabilization services may be provided for up to one year per job.

(b) An employment provider may subcontract with an industry to provide job coaching services to members who are eligible.

(1) ~~Agencies must obtain written approval from DDS and the consumer or legal guardian prior to the execution of a subcontract with industry. The subcontract with an industry must be reviewed and accepted by the Personal Support Team and member or legal guardian prior to the execution of the subcontract.~~

(2) ~~The Department's approval~~ Approval by OKDHS:
(A) of any subcontract does not relieve the primary vocational employment provider of any responsibility for performance under this Subchapter. per OAC 317:40-7; and

(B) ~~The Department's approval~~ to subcontract with an industry is given only when it is determined that the consumer's member's needs can best be met by additional natural supports provided by industry employees.

[OAR Docket #07-709; filed 4-5-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

[OAR Docket #07-698]

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Subchapter 5. Client Services
Part 5. Specialized Foster Care
317:40-5-55 [AMENDED]
Part 9. Service Provisions
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ANALYSIS:

Developmental Disabilities Services rules need revision to allow providers of Specialized Foster Care services as well as some service recipients' family members to receive reimbursement for transporting the person they serve. While DDS service recipients have transportation services authorized on their Plans of Care, under current rules neither Specialized Foster Care providers nor any family member are allowed to receive reimbursement for transporting the service recipient. These revisions will allow a family member other than the service recipient's spouse or the parent of a minor service recipient to contract to provide transportation services to work, medical appointments, or other activities identified in that person's Individual Plan. Rules are revised to allow providers of Specialized Foster Care services and certain service recipients' family members to be compensated for transportation services.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. CLIENT SERVICES

PART 5. SPECIALIZED FOSTER CARE

317:40-5-55. Specialized Foster Care provider responsibilities

(a) **General responsibilities.** The responsibilities of all Specialized Foster Care (SFC) providers are listed in this Sub-section.

(1) Providers of Specialized Foster Care (SFC) are required to meet all applicable standards outlined in OAC 317:40-5-40.

(2) Providers of SFC are required to receive competency based training as outlined in OAC 340:100-3-38. The provider keeps all required training up to date and submits documentation to the SFC specialist at the time training is completed.

(3) The provider participates as a member of the service recipient's Team and assists in the development of the service recipient's Individual Plan, as described in OAC 340:100-5-50 through 100-5-58.

(4) The provider documents and notifies the case manager of any changes in behaviors or medical conditions of the service recipient within one working day. Incident reports are completed by the SFC provider and submitted to the DDS area manager in accordance with OAC 340:100-3-34.

(5) The SFC provider is available to the service recipient at any time.

(6) The primary employment of the SFC provider is to provide SFC services to the service recipient. The SFC provider does not have other employment unless the other employment has been pre-approved by the supervisor of the DDS foster care unit.

(A) Generally, providers are not approved for other employment because the provider must be available before and after school or vocational programs and often during the day due to holidays or illnesses.

(B) If, after receiving approval for other employment, it is found that the SFC provider's employment interferes with the care, training, or supervision needed by the service recipient, the provider must determine if he or she wants to terminate the other employment or have the service recipient moved from the home.

(C) The DDS does not authorize Homemaker, Habilitation Training Specialist, or respite services in order for the SFC provider to perform other employment.

(7) The provider does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals With Disabilities Education Act (IDEA-B).

(8) The provider allows the service recipient to have experiences, both in and out of the home, to enhance the service recipient's development, learning, growth, independence, community inclusion, and well-being, while assisting the service recipient to achieve his or her maximum level of independence.

(9) The provider ensures confidentiality is maintained regarding the service recipient in accordance with the DDS confidentiality policy, OAC 340:100-3-2.

(10) The provider is sensitive to and assists the service recipient in participating in the service recipient's choice of religious faith. No service recipient is expected to attend any religious service against his or her wishes.

(11) The provider has a valid driver's license, maintains a motor vehicle in working order, and complies with requirements of OAC 317:40-5-103, Transportation.

(12) The provider arranges, and ensures that the service recipient obtains, a medical and a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed.

(13) The provider transports or arranges transportation, using adapted transportation when appropriate, for the service recipient to and from school, employment, church, recreational activities, and medical or therapy appointments.

(A) SFC providers who transport service recipients for Individual Plan activities more than an average of 30 miles a day may sign a transportation contract with approval from the DDS area programs manager for residential services. Authorization to provide transportation services is only made for transportation for specified activities in excess of the 30 miles per day average.

(B) The provider must assure availability and use of an approved and appropriate child auto restraint system as required by law in transporting children and, in cases of adults receiving services, any additional restraints identified as necessary in the Plan.

(14) The provider assures the person receiving services is clean, appropriately dressed, and on time for activities and appointments.

(15) The provider ensures no other adult or child is served in the home on a regular or part-time basis without prior approval from the DDS area manager or designee.

(16) The provider does not provide services to more than three individuals regardless of the type of service provided, including SFC, DCFS foster care, respite, baby-sitting, or other such services. Any exception to this paragraph must be approved in writing by the director of DDS or designee prior to authorization or service delivery.

(17) The provider permits visitation and monitoring of the home by authorized DDS staff. In order to assure maintenance of standards, some visits are unannounced. The visits occur at least monthly and are not intended to be intrusive but to ensure the safety and well-being of the service recipient.

(18) The provider encourages and cooperates in planning visits in the SFC home by relatives, guardians, or friends of the service recipient. Visits by the service recipient to the home of friends or relatives must be approved by the service recipient's legally authorized representative.

(19) The provider abides by the policies of DDS found at OAC 340:100-3-12, Prohibition of client abuse, and OAC 340:100-5-58, Prohibited procedures. The provider is prohibited from signing an authorization for school personnel to use physical discipline or corporal punishment.

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(20) The provider notifies the DDS case manager when the need arises for substitute supervision in the event of an emergency, in accordance with the Backup Plan, as specified in OAC 317:40-5-59.

(21) The provider provides written 30-day notice to the service recipient and DDS case manager when it is necessary for a service recipient to be moved from the home.

(22) The SFC provider does not serve as representative payee for the service recipient.

(23) The provider ensures the service recipient's funds are properly safeguarded.

(24) The provider assists the service recipient in accessing and using entitlement programs for which the service recipient may be eligible.

(25) The provider must use the room and board reimbursement payment to meet the service recipient's needs, as specified in the room and board contract.

(A) The provider retains a copy of the current room and board contract in the home at all times.

(B) Items purchased with the room and board reimbursement include, but are not limited to:

- (i) housing;
- (ii) food;
- (iii) clothing;
- (iv) care; and
- (v) incidental expenses such as:
 - (I) birthday and Christmas gifts;
 - (II) haircuts;
 - (III) personal grooming equipment;
 - (IV) allowances;
 - (V) toys;
 - (VI) school supplies and lunches;
 - (VII) school pictures;
 - (VIII) costs of recreational activities;
 - (IX) special clothing items required for dress occasions and school classes such as gym shorts and shirts;
 - (X) extracurricular athletic and other equipment, including uniforms, needed for the service recipient to pursue his or her particular interests or job;
 - (XI) prom and graduation expenses including caps, gowns, rings, pictures, and announcements;
 - (XII) routine transportation expenses involved in meeting the service recipient's medical, educational, or recreational needs, unless the provider has a transportation contract;
 - (XIII) non-prescription medication; and
 - (XIV) other maintenance supplies required by the service recipient.

(C) All items purchased for the service recipient with the room and board payment are the property of the service recipient and are given by the provider to the service recipient when a change of residence occurs.

(D) The room and board payment is made on a monthly basis and is prorated based on the actual days

the service recipient is in the home on the initial and final months of residence.

(26) The provider maintains a Personal Possession Inventory (DDS-22) for each service recipient living in the home.

(27) The provider maintains the service recipient's home record in accordance with OAC 340:100-3-40.

(28) The provider immediately reports to the DDS SFC staff all changes in the household including, but not limited to:

- (A) telephone number;
- (B) address;
- (C) marriage or divorce;
- (D) persons moving into or out of the home;
- (E) provider's health status;
- (F) provider's employment; and
- (G) provider's income.

(29) The provider maintains home owner's or renter's insurance, including applicable liability coverages, and provides a copy to the SFC Specialist.

(30) The provider serves as the Health Care Coordinator and follows the Health Care Coordinator policy outlined in OAC 340:100-5-26.

(31) Each SFC provider follows all applicable rules of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority, promotes the independence of the service recipient, and follows recommendations of the service recipient's Team.

(b) **Responsibilities specific to SFC providers serving children.** The provider is charged with the same general legal responsibility any parent has to exercise reasonable and prudent behavior in his or her actions and in the supervision and support of the child.

(1) The provider works with the DDS case manager and Division of Children and Family Services (DCFS) staff when the provider needs respite for a child in custody.

(2) The provider participates in the development of the Individual Education Plan (IEP) and may serve as surrogate parent when appropriate.

(3) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDS case manager prior to traveling out of state for an overnight visit. If the child is in the custody of the OKDHS, the permission of the DCFS specialist is also secured.

(4) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDS case manager prior to involvement of the child in any publicity. If the child is in OKDHS custody, the permission of the DCFS specialist is also secured.

(c) **Responsibilities specific to SFC providers serving adults.** Additional SFC provider responsibilities for serving adults are given in this Subsection.

(1) The provider obtains permission from the service recipient's legal guardian, when applicable, and notifies the DDS case manager, prior to:

- (A) traveling out of state for an overnight visit.
- (B) involvement of the service recipient in any publicity.

(2) When the service recipient is his or her own payee or has a representative payee, the provider ensures the monthly contribution for services as identified in a written agreement between the service recipient and the provider, is used toward the cost of food, rent, and household expenses.

(A) The service recipient's minimum monthly contribution is \$250.00 per month.

(B) Changes in the service recipient's monthly contribution are developed on an individualized basis by the service recipient's Team.

PART 9. SERVICE PROVISIONS

317:40-5-103. Transportation

(a) **General Information.** Transportation services include acquisition of, and payment for the use of, adapted, non-adapted, and public transportation.

(1) Transportation is provided to promote inclusion in the community, access to programs and services, and participation in activities to enhance community living skills.

(2) Services include, but are not limited to, transportation to and from medical appointments, work or employment services, recreational activities, and other community activities within the number of miles authorized in the Plan of Care.

(A) Adapted or non-adapted transportation is provided for each eligible person; or

(B) Public transportation is provided up to a maximum of \$5,000 per Plan of Care year. The director of DDS or designee may approve requests for public transportation services totaling more than \$5,000 per year if public transportation is the most cost-effective alternative. For the purposes of this Section, public transportation is defined as:

(i) public transportation services, such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) a transportation program operated by the service recipient's employment services or day services provider.

(3) Services are provided to eligible individuals service recipients in accordance with the person's service recipient's Plan of Care.

~~(4) Transportation services may be provided when there are insufficient supports to provide transportation.~~

~~(5) Authorization of Transportation Services is based on:~~

(A) Team consideration, in accordance with OAC 340:100-5-52, of the unique needs of the person and the most cost effective type of transportation services that meets the individual's service recipient's need, in accordance with subsection (d) of this Section;

(B) the person's service recipient's participation in Waiver services; and

(C) the scope of the transportation program as explained in this section.

(b) **Standards for transportation providers.** All drivers must have a valid and current Oklahoma drivers license, and the vehicle(s) must meet applicable local and state requirements for vehicle licensure, inspection, insurance, and capacity.

(1) The provider must ensure that any vehicle used to transport individuals service recipients:

(A) meets the needs of the service recipient;

(B) is maintained in a safe condition;

(C) has a current vehicle tag; and

(D) is operated in accordance with local, state, and federal law, regulation, and ordinance.

(2) The provider maintains liability insurance in an amount sufficient to pay for injuries or loss to persons or property occasioned by negligence or malfeasance by the agency, its agents, or employees.

(3) The transportation provider must adequately maintain equipment installed to provide supports for individuals service recipients.

(4) Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(A) the service date;

(B) the odometer mileage reading;

(C) the name of the service recipient transported;

(D) the purpose of the trip; and

(E) the starting point and destination.

(5) A family member, including a family member living in the same household, of an adult service recipient may establish a contract to provide transportation services to:

(A) work or employment services;

(B) medical appointments; and

(C) other activities identified in the Individual Plan as necessary to meet the needs of the service recipient, as defined in OAC 340:100-3-33.1.

(c) **Services not covered.** Services that cannot be claimed as transportation services include:

(1) services not approved by the Team;

(2) services not authorized by the Plan of Care;

(3) trips that have no specified purpose or destination;

(4) trips for family, provider, or staff convenience;

(5) transportation provided by the person receiving services, the service recipient's spouse, or a family member the mother or father of the person receiving services service recipient, if the service recipient is a minor;

~~(A) The Team may authorize a family member to provide:~~

~~(i) transportation to the service recipient's work or employment services; and~~

~~(ii) transportation provided in accordance with OAC 317:40-5-5 or OAC 317:40-5-55.~~

~~(B) For the purposes of this Section, a family member is defined as a:~~

~~(i) spouse;~~

~~(ii) mother or father of a minor child; or~~

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- (iii) ~~mother, father, sister, brother, or child, including those of in-law or step relationship, living in the same household;~~
- (6) ~~trips when the individual receiving services service recipient is not in the vehicle;~~
- (7) ~~transportation claimed for more than one service recipient per vehicle at the same time or for the same miles, except public transportation;~~
- (8) ~~transportation outside the State of Oklahoma unless:~~
- (A) ~~the transportation is provided to access the nearest available medical or therapeutic service; or~~
- (B) ~~advance written approval is given by the DDS Area Manager or designee;~~
- (9) ~~services which are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;~~
- (10) ~~transportation that occurs during the performance of the service recipient's paid employment, even if the employer is a contract provider.~~
- (d) **Assessment and Team process.** At least annually, the Team addresses the ~~person's~~ service recipient's transportation needs. The Team determines the most appropriate means of transportation based on the:
- (1) ~~present needs of the person receiving services. When addressing the possible need for adapted transportation, the Team considers the needs of the service recipient only. The needs of other individuals living in the same household are considered separately;~~
- (2) ~~person's service recipient's~~ ability to access public transportation services; and
- (3) ~~the availability of other transportation resources including family, neighbors, friends, and community agencies.~~
- (e) **Adapted Transportation.** Adapted transportation provides transportation in modified vehicles or vehicles specifically procured to meet medical or behavioral needs of the service recipient which cannot be met with the use of a standard passenger vehicle. Vehicle modifications that may be needed include, but are not limited to, wheelchair safe travel systems, wheelchair lifts, raised roofs and doors, and exterior mounted wheelchair or scooter carriers.
- (1) The Team determines if the ~~person~~ service recipient needs adapted transportation according to:
- (A) ~~the person's service recipient's~~ need for physical support when sitting;
- (B) ~~the person's service recipient's~~ need for physical assistance during transfers from one surface to another;
- (C) ~~the portability of the individual's service recipient's~~ wheelchair;
- (D) ~~associated health problems the individual service recipient may have; and~~
- (E) ~~behavioral issues related to vehicle travel; and,~~
- (F) ~~the needs of the individual only. The needs of other individuals living in the same household are considered separately.~~
- (2) The transportation provider and the equipment vendor ensure that requirements of the Americans with Disabilities Act are met when Team-recommended vehicle modifications are installed.
- (3) The transportation provider ensures that all staff assisting with transportation have been trained according to the requirements specified by the Team and the equipment manufacturer.
- (4) The adapted transportation rate is not paid when a vehicle has been adapted with funds from the HCBWS program.
- (f) **Authorization of transportation services.** The authorization limitations given in this subsection include the total of all transportation units on the Plan of Care, not just the units authorized for the residential setting identified.
- (1) ~~The Case Manager may include in the Plan of Care for a person receiving:~~ Up to 12,000 units of transportation services may be authorized in a service recipient's plan of care in accordance with OAC 340:100-3-33 and OAC 340:100-3-33.1.
- (A) ~~daily living supports, as defined in OAC 317:40-5-150, up to 12,000 units of adapted or non-adapted transportation per Plan of Care year;~~
- (B) ~~specialized foster care, as defined in OAC 317:40-5-50, no transportation units, since 30 miles per day are included in the specialized foster care rate;~~
- (C) ~~group home services, as defined in OAC 340:100-6-1, up to 12,000 units of adapted or non-adapted transportation per Plan of Care year;~~
- (D) ~~agency companion services, as defined in OAC 317:40-5-3, up to 12,000 units of adapted or non-adapted transportation per Plan of Care year;~~
- (E) ~~services in his or her own home or his or her family's home, up to 12,000 units of adapted or non-adapted transportation per Plan of Care year; or~~
- (F) ~~supported living services, the services specified in OAC 340:100-5-22.4.~~
- (2) ~~The Case Management Supervisor Area Manager or designee may include in the Plan of Care approve up to 14,400 miles per Plan of Care year for people receiving daily living supports, agency companion services, or services in the person's own home or family home who have extensive needs for transportation services.~~
- (3) ~~The DDS Service Authorization Unit may approve written requests for The Division Director or designee may approve:~~
- (A) ~~transportation services in excess of 14,400 miles per Plan of Care year in extenuating situations when person-centered planning has identified specific needs which require additional transportation for a limited period; or~~
- (B) ~~any combination of public transportation services with adapted or non-adapted transportation; or~~

(C) public transportation services in excess of \$5000 when this is the most cost effective service option for necessary transportation.

[OAR Docket #07-698; filed 4-5-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**

[OAR Docket #07-699]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 1. General Provisions
317:45-1-2 through 317:45-1-3 [AMENDED]
317:45-1-4 [NEW]
- Subchapter 3. O-EPIC PA Carriers
- Subchapter 5. O-EPIC PA Qualified Health Plans
317:45-5-1 [AMENDED]
- Subchapter 9. O-EPIC PA Employee Eligibility
317:45-9-3 [AMENDED]
317:45-9-5 [REVOKED]
317:45-9-7 [AMENDED]
- Subchapter 11. O-EPIC IP [NEW]
Part 1. Individual Plan Providers [NEW]
317:45-11-1 through 317:45-11-2 [NEW]
Part 5. O-EPIC Individual Plan Member Eligibility [NEW]
317:45-11-21 through 317:45-11-28 [NEW]
(Reference APA WF # 06-08)

AUTHORITY:

Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; O.S. §68-302-5 et seq.

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Failure of the Legislature to disapprove the rule(s) resulted in approval on April 4, 2007

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Superseded rules:

- Subchapter 1. General Provisions
317:45-1-2 through 317:45-1-3 [AMENDED]
317:45-1-4 [NEW]
- Subchapter 3. O-EPIC PA Carriers
- Subchapter 5. O-EPIC PA Qualified Health Plans
317:45-5-1 [AMENDED]
- Subchapter 9. O-EPIC PA Employee Eligibility
317:45-9-3 [AMENDED]
317:45-9-5 [REVOKED]

- 317:45-9-7 [AMENDED]
Subchapter 11. O-EPIC IP [NEW]
Part 1. Individual Plan Providers [NEW]
317:45-11-1 through 317:45-11-2 [NEW]
Part 5. O-EPIC Individual Plan Member Eligibility [NEW]
317:45-11-21 through 317:45-11-28 [NEW]

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INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Agency rules are issued to establish criteria that implements the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Individual Plan. Last fall, the agency initiated the O-EPIC Premium Assistance program for small Oklahoma's business employers with 25 employees or less. The O-EPIC Individual Plan program extends affordable health coverage to low income employees who cannot afford to participate in their employer's health plan, employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability. The Program is funded through a portion of monthly proceeds from the Tobacco Tax that are collected and dispersed through the Health Employee and Economy Improvement Act (HEEIA) Revolving Fund. In addition, rules for the O-EPIC Premium Assistance program are revised to: (1) allow employees with multiple employers to qualify for inclusion in the O-EPIC PA program if their primary employer meets eligibility guidelines; (2) add several definitions to rules; and (3) remove unnecessary requirements that are not being used in the current program.

CONTACT PERSON:

Joanne Terlizzi at 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-2. Program limitations

- (a) The O-EPIC program is contingent upon sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.
- (b) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the Program.
- (c) The Program is funded through a portion of monthly proceeds from the Tobacco Tax, House Bill 2660 O.S.S. §68-302-5 et seq., that are collected and dispersed through the HEEIA revolving fund, pursuant to Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes.
- (d) The Program is limited in scope such that budgetary limits are available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there

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is risk the budgetary limits available funding may be exceeded, OHCA must take action to ensure the O-EPIC program continues to operate within its fiscal capacity.

- (1) O-EPIC may limit eligibility based on:
 - (A) the federally-approved capacity of the O-EPIC services for the Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver; and
 - (B) Tobacco Tax collections.
- (2) The O-EPIC program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list of employers.
 - (A) Employers Applicants, not previously enrolled and participating in the program, submitting new applications for the O-EPIC program are placed on a waiting list. These applications are date and time stamped by region when received by the TPA. Applications are identified by region and O-EPIC program. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. O-EPIC program size is determined by OHCA and may be periodically adjusted.
 - (B) The waiting list utilizes a "first in - first out" method of selecting eligible employers applicants by region and O-EPIC program.
 - (C) When an employer group applicant is determined eligible and moves from the waiting list to active participation, the employer applicant must submit a new application. All eligible employees of that employer will have an opportunity to participate in O-EPIC during the employer's eligibility period.
 - ~~(D) Only employers will be subject to the waiting list.~~
 - ~~(E) Enrolled employers applicants~~ who are currently participating in the O-EPIC program are not subject to the waiting list.
 - ~~(F) For approved employers of O-EPIC, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate in O-EPIC during the employer's current eligibility period.~~
 - ~~(G) For approved employers of O-EPIC, if the employer has an employee who has a Qualifying Event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the Qualifying Event.~~

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

- (A) an insurance company, group health service or Health Maintenance Organization (HMO) that provides health benefits pursuant to Title 36 O.S., Section 6512;

(B) A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department; or

(C) A domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a Carrier that indicates services rendered and financial responsibilities for the Carrier and O-EPIC PA member.

"Individual Plan" means the O-EPIC program that provides services to those individuals who do not meet the criteria for O-EPIC PA.

"O-EPIC" means the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

"O-EPIC IP" means the Individual Plan program.

"O-EPIC PA" means the Premium Assistance program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"Oklahoma Employer and Employee Partnership for Insurance Coverage" means a health plan purchasing strategy in which a state uses public funds to pay for a portion of the premium costs of employer-sponsored health plans plan coverage for eligible populations.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Premium Assistance" means the O-EPIC program that provides premium assistance to small business for certain employees.

"Primary Care Provider" means a provider under contract to the Oklahoma Health Care Authority to provide primary care services, including all medically-necessary referrals.

"Primary Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Premium" means a monthly payment to a Carrier for health plan coverage.

"OHP" means Qualified Health Plan

"Qualified Health Plan" means a health plan that has been approved by the OHCA for participation in the O-EPIC program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying Events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority or its designee.

"TPA" means the Third Party Administrator.

"Third Party Administrator" means the entity contracted by the State to provide the administration of the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

317:45-1-4. Reimbursement for out-of-pocket medical expenses

(a) O-EPIC members are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed 5% of the employee's gross annual household income during the current eligibility period may be reimbursable.

(b) The O-EPIC member must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period. Appropriate supporting documentation includes an original EOB or paid receipt if no EOB is issued. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses. Appropriate supporting documentation for prescribed prescriptions must be an original receipt and include information about the pharmacy at which the drug was purchased, the name of the drug dispensed, the quantity dispensed, the prescription number, the name of the person the drug is for, the date the drug was dispensed and the total amount paid.

(c) Reimbursement for qualified medical expenses is subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the 5% threshold would be absorbed.

SUBCHAPTER 3. O-EPIC PA CARRIERS

SUBCHAPTER 5. O-EPIC PA QUALIFIED HEALTH PLANS

317:45-5-1. Qualified Health Plan requirements

(a) Qualified Health Plans participating in O-EPIC must offer, at a minimum, benefits that include:

- (1) hospital services;
- (2) physician services;
- (3) clinical laboratory and radiology;
- (4) pharmacy; and
- (5) office visits.

(b) The health plan, if required, must be approved by the Oklahoma Department of Insurance for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

- (1) An annual out-of-pocket maximum cannot exceed \$3,000 per individual. This amount includes any individual, annual deductible amount, except for pharmacy.
- (2) Office visits cannot require a co-payment exceeding \$50 per visit.
- (3) Annual pharmacy deductibles cannot exceed \$500 per individual.

(c) Qualified Health Plans may provide an Explanation of Benefits (EOB) for paid or denied claims subject to member co-insurance or member deductible calculations. If an EOB is provided it must contain, at a minimum, the:

- (1) provider's name;
- (2) patient's name;
- (3) date(s) of service;
- (4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
- (5) reason code(s) and description(s) for any denied service(s); and
- (6) amount due and/or paid from the patient or responsible party.

SUBCHAPTER 9. O-EPIC PA EMPLOYEE ELIGIBILITY

317:45-9-3. Qualifying Event

(a) Employees are allowed ~~30 calendar days~~ to apply for O-EPIC following a Qualifying Event.

(b) An employee's spouse may become eligible for coverage and is allowed ~~30 calendar days~~ to apply for O-EPIC following a Qualifying Event of the employee or spouse.

317:45-9-5. Reimbursement for out-of-pocket medical expenses

(a) ~~Employees are responsible for all out of pocket expenses. Out of pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed 5% of the employee's gross annual household income during the current eligibility period may be reimbursable.~~

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(b) The employee must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period. Appropriate supporting documentation includes an original EOB or paid receipt. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses, including prescribed prescriptions.

(c) Reimbursement for qualified medical expenses are subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the 5% threshold would be absorbed.

317:45-9-7. Closure

(a) Employer and employees' employee eligibility are tied together. If the employer no longer meets the requirements for O-EPIC then eligibility for the associated employees enrolled under that employer are also ineligible. Employees are mailed a written notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

- (1) termination of employment, either voluntary or involuntary, occurs;
- (2) the employee moves out-of-state;
- (3) the covered employee dies;
- (4) the employer ends its contract with the Qualified Health Plan;
- (5) the employer's eligibility ends;
- (6) an audit indicates a discrepancy that makes the employee or employer ineligible;
- (7) the employer is terminated from O-EPIC;
- (8) the employer fails to pay the premium;
- (9) the Qualified Health Plan or Carrier is no longer qualified;
- (10) the employee becomes eligible for Medicaid/Medicare;
- (11) the employee or employer reports to the OHCA or the TPA any change affecting eligibility; or
- (12) the employee is no longer listed as a covered person on the employer's health plan invoice; or
- (13) the employee requests closure.

SUBCHAPTER 11. O-EPIC IP

PART 1. INDIVIDUAL PLAN PROVIDERS

317:45-11-1. O-EPIC Individual Plan providers

O-EPIC Individual Plan (IP) providers must comply with existing SoonerCare rules found at OAC 317:25 and OAC 317:30. In order to receive SoonerCare reimbursement, the IP provider:

- (1) must enter into a SoonerCare contract;
- (2) may collect the member's co-pay in addition to the SoonerCare reimbursement;
- (3) may refuse to see members based on their inability to pay their co-pay; and
- (4) must complete O-EPIC IP addendum if provider wants to provide primary care services as a PCP.

317:45-11-2. O-EPIC IP provider payments

Payment for covered benefits, as shown in OAC 317:45-11-10, rendered to O-EPIC IP members is made to contracted O-EPIC IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in OAC 317:30-3-1(f). Coverage of certain services requires prior authorization as shown in OAC 317:45-11-10 and may be based on a determination made by a medical consultant in individual circumstances.

PART 5. O-EPIC INDIVIDUAL PLAN MEMBER ELIGIBILITY

317:45-11-21. Spouse eligibility

(a) If the spouse of an O-EPIC IP approved individual is eligible for O-EPIC IP, they must apply for O-EPIC IP. Spouses cannot obtain O-EPIC IP coverage if they are eligible for O-EPIC IP.

(b) The spouse of an applicant approved according to the guidelines listed in OAC 317:45-11-20(a) through (h) is eligible for O-EPIC IP.

(c) The spouse of an applicant approved according to the guidelines listed in OAC 317:45-11-20(i) does not become automatically eligible for O-EPIC IP. The spouse may choose to apply separately.

(d) The applicant and the spouses' eligibility are tied together. If the applicant no longer meets the requirements for O-EPIC IP, then the associated spouse enrolled under that applicant is also ineligible.

317:45-11-22. PCP choices

(a) The applicants (and spouse if also applying for O-EPIC IP) are required to select valid PCP choices as required on the application.

(b) If a valid PCP is selected by the applicant or spouse and they are not enrolled with the first PCP choice, they are enrolled with the next available PCP choice. The applicant is notified in writing why their choice was not selected.

(c) After initial enrollment in O-EPIC IP, the applicant or spouse can change their PCP selection by calling the O-EPIC helpline. Changes take effect the first day of the next month or the first day of the 2nd consecutive month. Applicant and spouse are only allowed to change their PCP a maximum of four times per calendar year.

317:45-11-23. Employee eligibility period

(a) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a)-(f).

(1) The employee's coverage period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on 1-14-06 and the premium is received before 2-15-06, eligibility begins 3-1-06; or an application is received and approved 1-15-06 and the premium is received on 3-15-06, eligibility begins 4-1-06.)

(B) If premiums are paid early, eligibility still begins as scheduled.

(2) Employee eligibility is contingent upon the employer's program eligibility.

(3) The employee's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20(a)-(f).

(4) If the employee is determined eligible for O-EPIC IP, he/she is approved for a period not greater than 12 months. The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period as defined in OAC 317:45-7-1, 317:45-7-2 and 317:45-7-8.

(b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a)-(d) and 317:45-11-20(g)-(i).

(1) The applicant's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-11-20(a)-(d) and 317:45-11-20(g)-(i).

(2) If the applicant is determined eligible for O-EPIC IP, he/she is approved for a period not greater than 12 months.

(3) The applicant's eligibility period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on 1-14-06 and the premium is received before 2-15-06, eligibility begins 3-1-06; or an application is approved 1-15-06 and the premium is received on 3-15-06, eligibility begins 4-1-06.)

(B) If premiums are paid early, eligibility still begins as scheduled.

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their gross monthly household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed 4% of their gross monthly household income, based on a family size of one and capped at 151% of the Federal Poverty Level.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as result of Insufficient/Non-sufficient funds.

317:45-11-25. Premium payment

(a) O-EPIC IP premiums are based upon a percentage of the Federal Poverty Level (FPL) income guidelines. The FPL income guidelines are determined annually by the Federal Government.

(b) Monthly premiums in the IP program vary based on:

(1) income reported on the member's application; and

(2) a family size of one for single coverage or a family size of two for dual coverage.

317:45-11-26. Audits

Members participating in the O-EPIC program are subject to audits related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-11-27. Closure

(a) Members are mailed a written notice 10 days prior to closure of eligibility.

(b) Employer and employees eligibility are tied together. If the employer no longer meets the requirements for O-EPIC then eligibility for the associated employees enrolled under that employer are also ineligible.

(c) The employee's certification period may be terminated when:

- (1) the member requests closure;
- (2) the member moves out-of-state;
- (3) the covered member dies;
- (4) the employer's eligibility ends;
- (5) an audit indicates a discrepancy that makes the member or employer ineligible;
- (6) the employer is terminated from O-EPIC;
- (7) the member fails to pay the premium as well as any other amounts on or before the due date;
- (8) the Qualified Health Plan or Carrier is no longer qualified;
- (9) the member becomes eligible for Medicaid/Medicare; or
- (10) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

(d) This subsection applies to applicants eligible according to OAC 317:45-11-20 (a)-(d) and 317:45-11-20(g)-(i). The member's certification period may be terminated when:

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- (1) the member requests closure;
- (2) the member moves out-of-state;
- (3) the covered member dies;
- (4) the employer's eligibility ends;
- (5) an audit indicates a discrepancy that makes the member or employer ineligible;
- (6) the member fails to pay the premium;
- (7) the member becomes eligible for Medicaid/Medicare; or
- (8) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

317:45-11-28. Appeals

- (a) Member appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.
- (b) Member appeals related to premium payments and/or out-of-pocket expenses are made to the TPA. If the member disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.
- (c) Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.

[OAR Docket #07-699; filed 4-5-07]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 15. LICENSING

[OAR Docket #07-645]

RULEMAKING ACTION:

PERMANENT final adoption

RULE:

Subchapter 5. Occupation Licensing

325:15-5-15. Physical examination [AMENDED]

325:15-5-21. Licensing required prior to entry or scratch time [AMENDED]

AUTHORITY:

75 Oklahoma Statutes §§302, 305, and 307; Title 3A O.S., §204(A); Oklahoma Horse Racing Commission

DATES:

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November 15, 2006 through December 17, 2006

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Effective:

May 11, 2007

SUPERSEDED EMERGENCY ACTIONS:

Not Applicable

INCORPORATED BY REFERENCE:

Not Applicable

ANALYSIS:

Amendment to Rule 325:15-5-15 responds to a request from the Board of Stewards to update the requirement. In its current fashion, the rule requires that all riders must provide written proof of a satisfactory physical exam within the past 12 months. In today's environment, riders fly into Oklahoma to participate in one race and promptly return to their home base. It is, therefore, a tremendous burden for an out-of-town jockey who would typically appear just hours prior to post time to provide such proof of examination. Not every jurisdiction requires such proof. This rule change does not, however, absolve jockeys from the requirement of physical exams should the Stewards deem it necessary.

Amendment to Rule 325:15-5-21 makes consistent the completion of licensing procedures before starting the horse rather than prior to entry which may potentially cause hardship on a Trainer shipping into Oklahoma from another racing jurisdiction. The license requirement is universal and will be required except that the proposed change eases the time requirements.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. OCCUPATION LICENSING

325:15-5-15. Physical examination

~~A Jockey, Apprentice Jockey, or Exercise Rider must provide written proof of a satisfactory physical examination within the previous twelve (12) months. Such examination shall have been given by a licensed physician and shall include visual acuity and hearing examinations. The Commission or the Stewards may require that a Jockey, Apprentice Jockey, or Exercise Rider be re-examined examined by a medical professional at any time; be required to provide a copy of a physical examination; or submit a release-to-work document prior to returning to work when previously injured. and the The Commission or the Stewards may refuse to allow that person to ride until s/he has successfully passed such examination satisfied these requirements.~~

325:15-5-21. Licensing required prior to entry or scratch time

The licensing procedures required by the Commission for all participants must be completed prior to entry of starting the horse except that ownership licensing must be completed prior to scratch time for that horse and shall include all registrations, statements and payment of fees, ~~or the Stewards can allow up to scratch time for that entry in a stakes event or one (1) hour prior to post time for the first race of that race program. However, a Trainer who is in a nomination race and who is a licensed Trainer in a recognized jurisdiction reciprocating~~

with the Oklahoma Horse Racing Commission shall have until scratch time for that race to complete the reciprocity licensing requirements as approved by the Commission.

[OAR Docket #07-645; filed 4-3-07]

**TITLE 325. OKLAHOMA HORSE RACING COMMISSION
CHAPTER 25. ENTRIES AND DECLARATIONS**

[OAR Docket #07-646]

RULEMAKING ACTION:

PERMANENT final adoption

RULE:

325:25-1-10. Horses ineligible to start in a race [AMENDED]

325:25-1-17. Coupling of entries [AMENDED]

AUTHORITY:

75 Oklahoma Statutes §§302, 305, and 307; Title 3A O.S., §204(A); Oklahoma Horse Racing Commission

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SUPERSEDED EMERGENCY ACTIONS:

Not Applicable

INCORPORATED BY REFERENCE:

Not Applicable

ANALYSIS:

Amendment to Rule 325:25-1-10 brings this rule into compliance with Rule 325:15-5-21, Licensing Required Prior to Entry or Scratch Time, in which a horse becomes ineligible if all parties are not licensed prior to starting in a race.

Amendment to Rule 325:25-1-17 deletes the requirement that the horses entered in the same race owned wholly or in part by the same Owner are trained by the same Trainer.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

325:25-1-10. Horses ineligible to start in a race

In addition to any other valid ground or reason, a horse is ineligible to start in any race if:

(1) Such horse is not registered by The Jockey Club if a Thoroughbred; the American Quarter Horse Association if a Quarter Horse; the Appaloosa Horse Club if an Appaloosa; the Arabian Horse Club Registry of America if an Arabian; the American Paint Horse Association if a Paint; the Pinto Horse Association of America, Inc., if a Pinto; or any successors to any of the foregoing or other registry recognized by the Commission.

(2) The original, replacement, or corrected Certificate of Foal Registration, or other registration issued by the official registry for such horse is not on file with the Racing Secretary prior to entry for the race in which the horse is scheduled to race. The Stewards may make exceptions in certain stakes and races which are not overfilled, in which case such Foal Certificate must be on file no later than one (1) hour prior to post time for the first race of that race program, except that in emergency situations for finals and stakes races, the Stewards may allow a horse to start in a race if an acceptable photocopy of the Foal Certificate is provided by a representative of a turf governing body, a licensed racetrack or a breed registry, and the original Foal Certificate is on file with that entity. However, under no circumstances shall any money earned be paid to said starter until the original, replacement, or corrected Foal Certificate is received by the Stewards so that all information may be verified and any eligibility notations recorded on or attached to the Foal Certificate.

(3) Such horse has been entered or raced at any recognized race meeting under any name or designation other than the name or designation duly assigned by and registered with the official registry.

(4) The Win Certificate, Certificate of Foal Registration, eligibility papers, or other registration issued by the official registry has been materially altered, erased, removed, or forged.

(5) Such horse is ineligible to enter said race, is not duly entered for such race, or remains ineligible to time of starting.

(6) The ownership and Trainer of such horse has not completed the prescribed licensing procedures required by the Commission before the appropriate scratch time or entry pursuant to Commission Rule starting the horse, or the horse is in the care of an unlicensed Trainer.

(7) Such horse is owned in whole or in part or trained by any person who is suspended or ineligible for a license or ineligible to participate under the rules of any Turf Governing Authority or Stud Book Registry.

(8) Such horse is a suspended horse.

(9) Such horse is on the Stewards' List, Starter's List, or the Veterinarian's List.

(10) Except with permission of the Stewards and Horse Identifier, the identification markings of the horse do not agree with the identification as set forth on the Registration Certificate to the extent that a correction is required from the appropriate breed registry.

- (11) Except with the permission of the Stewards, the horse has not been lip tattooed by a Commission-approved Tattooer.
- (12) The entry of a horse is not in the name of its true Owner.
- (13) The horse has drawn into the field or has started in a race on the same day.
- (14) The age of the horse as determined by an examination of its teeth by the Official Veterinarian does not correspond to the age shown on its Registration Certificate, such determination by tooth examination to be made in accordance with the current OFFICIAL GUIDE FOR DETERMINING THE AGE OF THE HORSE as adopted by the American Association of Equine Practitioners.
- (15) The Certificate of Registration of a horse reflects an unknown sire or dam.
- (16) An ownership transfer for a claimed horse is being processed by the Racing Secretary to a breed registry, and an acceptable photocopy of the Foal Certificate is not on file with the Racing Secretary.
- (17) A horse is wholly or partially owned by a disqualified person, or a horse is under the direct or indirect management of a disqualified person.
- (18) A horse is wholly or partially owned by the spouse of a disqualified person or a horse is under the direct or indirect management of the spouse of a disqualified person, in such cases, it being presumed that the disqualified person and spouse constitute a single financial entity
- (19) The horse is a cloned horse.

325:25-1-17. Coupling of entries

In no case shall more than two (2) horses having common ties through ownership, training, or lease be entered in a purse race (overnight). When making a double entry, the second same owner entry drawn shall have no preference over any single entry in purse races, excepting a preference over an "in-today" horse. If horses are entered in the same race owned wholly or in part by the same Owner ~~and trained by the same Trainer~~, then that entry shall be coupled for wagering purposes. At the time of entry, a preference must be made to the end that each interest may have an entry in each division should the race be divided. For different Owners, an organization licensee, with approval of the Stewards, may allow for each entrant to have an equal shake to draw into a race providing the horse(s) have preference. Horses with identical ownership interests regarding prepayment, nomination and stakes races must be coupled in races which have an incremental purse payout from first to last. If a race is to be divided, an additional conditional entry may be accepted from any interest. Each such entry may have a joint entry. All divided races will be considered separate races.

[OAR Docket #07-646; filed 4-3-07]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 30. CLAIMING RACES

[OAR Docket #07-647]

RULEMAKING ACTION:

PERMANENT final adoption

RULE:

325:30-1-17. Entry of claimed horse [AMENDED]

AUTHORITY:

75 Oklahoma Statutes §§302, 305, and 307; Title 3A O.S., §204(A); Oklahoma Horse Racing Commission

DATES:

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SUPERSEDED EMERGENCY ACTIONS:

Not Applicable

INCORPORATED BY REFERENCE:

Not Applicable

ANALYSIS:

The Commission earlier adopted amendments at the September 15, 2005 meeting to make uniform the eligibility requirements so that a horse claimed in another state would be handled as all other claimed horses in the jurisdiction in which the horse was claimed. The Governor approved the amendments on November 3, 2005 with Legislative approval on March 31, 2006 with the amendments considered effective May 11, 2006. Since the effective date of the earlier amendments, there was confusion about where a Thoroughbred horse may participate, so additional amendments were proposed for clarification.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE IS CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

325:30-1-17. Entry of claimed horse

(a) A horse claimed out of a claiming race shall be eligible to race at any racing organization within the State of Oklahoma immediately or in any other state after the end of the race meeting where the claim occurred. A claimed horse shall not be eligible to start in any other claiming race for a period of thirty (30) days exclusive of the day such horse was claimed for less than the price for which the horse was claimed. A claimed

horse, with permission of the Stewards at that race meeting, may be allowed to participate in stakes or nomination races in other jurisdictions. A horse claimed in another racing jurisdiction is subject to the eligibility requirements for the claimed horse in effect at the time of the claim in the jurisdiction in which the horse was claimed.

(b) Any Thoroughbred horse claimed at a race meeting in Oklahoma shall not be eligible to start in a claiming race in which the claiming price is less than 25 percent more than the price at which it was claimed for a period of 30 days, exclusive of the day the horse was claimed. A claimed Thoroughbred horse shall be eligible to enter a race whenever necessary so that the horse may start on the 31st day following the claim, for any claiming price.

(c) Any Thoroughbred horse claimed at a race meeting in Oklahoma will not be eligible to start in any race, exclusive of a stakes race, at any other ~~tracks~~ jurisdiction until the end of the race meeting at which the horse was claimed. A claimed Thoroughbred horse may, however, be granted approval to compete in stakes races at other tracks in other jurisdictions during this time period if granted permission by the stewards at the track at which the horse was claimed.

[OAR Docket #07-647; filed 4-3-07]

**TITLE 325. OKLAHOMA HORSE RACING
COMMISSION
CHAPTER 35. GENERAL CONDUCT**

[OAR Docket #07-649]

RULEMAKING ACTION:

PERMANENT final adoption

RULE:

325:35-1-5. Trainer responsibility [AMENDED]

AUTHORITY:

75 Oklahoma Statutes §§302, 305, and 307; Title 3A O.S., §204(A); Oklahoma Horse Racing Commission

DATES:

Comment Period:

May 15, 2006 through June 18, 2006

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June 19, 2006

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

325:35-1-5. Trainer responsibility [AMENDED]

Gubernatorial approval:

May 9, 2006

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23 Ok Reg 2069

Docket number:

06-1140

INCORPORATED BY REFERENCE:

Not Applicable

ANALYSIS:

Created in December, 2005, the Commission's Ad Hoc Committee on Drug Testing Rules, concluded in March, 2006 after months of research, consultation with experts in the field, and careful consideration that Oklahoma's current Rules pertaining to Medication and Equine Drug Testing Procedures and Veterinarian Practices were contrary to the rapidly changing science and technology which exists with regard to procedures for effective use of safe and necessary therapeutic medication. Additionally, many states throughout the country, including but not limited to surrounding states in the region, have made similar changes to their equine drug testing rules. As part of the recent work of the Commission's Ad Hoc Committee on Equine Drug Testing Rules, amendment to this rule was proposed to consistently reflect the changes made in Chapter 40, Veterinarian Practices, and Chapter 45, Medication and Equine Testing Procedures.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE IS CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

325:35-1-5. Trainer responsibility

(a) The Trainer is presumed to know the rules of racing and is responsible for the condition, soundness, and eligibility of the horses s/he enters in a race. The Trainer shall conduct his/her business of training racehorses with reasonable care and skill and in a humane manner, and with due regard to the interests of his/her owners and to the safety of employees and agents and of the horses in his/her care. Should the chemical analysis, urine or otherwise, taken from a horse under his/her supervision show the presence of any drug or medication ~~of any kind or substance, whether drug or otherwise, regardless of the time it may have been administered~~ except as otherwise provided for in Chapter 45, it shall be taken as prima facie evidence that the same was administered by or with the knowledge of the Trainer or person or persons under his/her supervision having care or custody of such horse. At the discretion of the Stewards or Commission, the Trainer and all other persons shown to have had care or custody of such horse may be fined or suspended or both. Under the provisions of this Section, the Trainer is also responsible for any puncture mark on any horse s/he enters in a race, found by the Stewards upon recommendation of the Racing or Official Veterinarian to evidence injection by syringe. If the Trainer cannot be present on race days s/he shall designate an Assistant Trainer. Such designation shall be made prior to time of entry, unless otherwise approved by the Stewards. Failure to fully disclose the actual Trainer of a horse participating in an approved race shall be grounds to disqualify the horse and subject the actual Trainer to possible disciplinary action by the Stewards or the Commission. Designation of an Assistant Trainer shall not relieve the Trainer's absolute responsibility for the conditions and eligibility of the

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horse, but shall place the Assistant Trainer under such absolute responsibility also. Willful failure on the part of the Trainer to be present at, or refusal to allow the taking of any specimen, or any act or threat to prevent or otherwise interfere therewith shall be cause for disqualification of the horse involved; and the matter shall be referred to the Stewards for further action.

(b) In addition to the responsibilities of (a) of this Section, a Trainer has the following specific responsibilities:

- (1) Knowledge of medication rules;
 - (2) Knowledge of medication status of all horses in his/her care;
 - (3) Knowledge of Furosemide (Salix) use rules;
 - (4) To register all horses in his/her care with the Racing Secretary;
 - (5) To ensure that no injectable substances, hypodermic needles, syringes, or electrical or mechanical device (other than the ordinary whip or approved twitch) which may or can be used for the purpose of stimulating or depressing a horse or affecting its speed at any time are in his/her possession; in the possession of employees; or in automobiles; or in sleeping, storage or stable areas owned by or assigned to that Trainer or Trainer's employees;
 - (6) Proper entering and eligibility of all horses in his/her care;
 - (7) Guard horses in his/her care;
 - (8) Make any declaration or scratch of an entered horse in his/her care;
 - (9) Bill and account for fees and services rendered on behalf of any horse in his/her care to the appropriate Owner or Owners.
 - (10) To instruct and determine the training regimen of all horses in his/her care and entered in any race.
- (c) No Trainer duty or responsibility, whether listed in (a) or (b) of this Section or not, may be assigned to any person who is ineligible to hold a license or who is under suspension in this or any other racing jurisdiction.
- (d) No licensed Trainer shall assume any of the responsibilities described in this Section for a horse not under his/her active care, supervision or custody.

[OAR Docket #07-649; filed 4-3-07]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 35. GENERAL CONDUCT

[OAR Docket #07-648]

RULEMAKING ACTION:

PERMANENT final adoption

RULE:

325:35-1-17. Illegal or improper communications equipment or devices [REVOKED]

325:35-1-38. Prohibited provisions of horsemen's agreements [AMENDED]

AUTHORITY:

75 Oklahoma Statutes §§302, 305, and 307; Title 3A O.S., §204(A); Oklahoma Horse Racing Commission

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SUPERSEDED EMERGENCY ACTIONS:

Not Applicable

INCORPORATED BY REFERENCE:

Not Applicable

ANALYSIS:

The repeal of Rule 325:35-1-17 is due to today's day and age of technology. In addition, the Commission is not staffed to confiscate every unauthorized cell phone, PDA or two-way radio communication system.

Amendment to Rule 325:35-1-38 was made to be in compliance with Section 264, Race Meetings - Number Required, in the State-Tribal Gaming Act. Section 264 specifies the number of races by breed at a particular racetrack as well as the parameters of the number of races per race day.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

325:35-1-17. Illegal or improper communications equipment or devices

~~No person shall have in his/her possession within any racing enclosure any telephonic, radio, or other signaling or communication equipment or device unless such equipment or device has been approved and its use within the enclosure authorized by the Commission. Any such communication equipment or device not approved and authorized by the Commission is subject to confiscation.~~

325:35-1-38. Prohibited provisions of horsemen's agreements

(a) No agreement between the Organization Licensee and the horsemen shall include therein any provision which is in conflict with the Oklahoma Horse Racing Act, the State-Tribal Gaming Act, the *Rules of Racing* of the Commission, the Interstate Horse Racing Act or any other laws or which usurps the authority of the Commission, including but not limited to:

(1) ~~Any provision which limits or specifies the number of races to be programmed on any day or night of the race meeting;~~

(2) ~~Any provision which specifies the number of days per week during which racing will be conducted at the race meeting;~~

(3) Any provision which specifies the type of pari-mutuel wagering to be conducted by the Organization Licensee or the number of multiple wager (exotic) pari-mutuel pools to be conducted; or

(4) Any provision which may serve to exclude participation at the race meeting by any individual holding a valid license issued by the Commission.

(b) Nothing herein shall be deemed as an abridgement of the provision of Commission Rule 325:15-5-6 and Commission Rule 325:35-1-29.

[OAR Docket #07-648; filed 4-3-07]

**TITLE 325. OKLAHOMA HORSE RACING COMMISSION
CHAPTER 45. MEDICATION AND EQUINE TESTING PROCEDURES**

[OAR Docket #07-650]

RULEMAKING ACTION:

PERMANENT final adoption

RULE:

325:45-1-9. Furosemide (Salix) use without detention barn [AMENDED]
325:45-1-28. Report of treatment: Procaine Penicillin administration [AMENDED]

AUTHORITY:

75 Oklahoma Statutes §§302, 305, and 307; Title 3A O.S., §204(A); Oklahoma Horse Racing Commission

DATES:

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SUPERSEDED EMERGENCY ACTIONS:

Not Applicable

INCORPORATED BY REFERENCE:

Not Applicable

ANALYSIS:

Amendment to Rule 325:45-1-9 expands the horses subject to blood and/or urine sample to determine Salix levels and/or presence of other drugs. Currently, only horses that finish first, second or third are subject to the sample.

Amendment to Rule 325:45-1-28 is made in light of several incidents involving the reporting of Procaine Penicillin use. Commission Staff believed that a review of the rule was in order to clarify that Trainers based at locations other than licensed racetracks may present treatment verification forms by someone other than a licensed veterinarian. Currently, the rule is restrictive as it only applies to those treated horses that are stabled on racetrack grounds.

CONTACT PERSON:

Bonnie Morris, Assistant to the Administrator, Oklahoma Horse Racing Commission, Shepherd Mall, 2614 Villa Prom, Oklahoma City, OK 73107, (405) 943-6472

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

325:45-1-9. Furosemide (Salix) use without detention barn

The use of Furosemide (Salix) shall be permitted under the following conditions:

- (1) The dose shall be administered intravenously.
- (2) The Commission has established a post race plasma concentration level not to exceed 100 ng/ml of Furosemide (Salix).
- (3) Any treated horse ~~which finished first, second or third shall~~ may be subject to having a blood and/or urine sample taken at the direction of the Official Veterinarian to determine the quantitative Furosemide (Salix) levels and/or the presence of other drugs which may be present in the blood or urine sample. The cost of such testing shall be at the expense of the Owner.
- (4) The permitted quantitative Furosemide (Salix) level (tolerance level) shall not exceed the tolerance level established by Commission directive [3A:205.2(H)]. Said directive shall be conspicuously posted within the enclosure by the Official Veterinarian.
- (5) The Stewards shall impose a fine of Five Hundred Dollars (\$500.00) for any Trainer in violation of this Section for a first time offense. For a second time offense involving the same horse in a one (1) year period for violation of this Section, the Stewards shall impose a fine of Dollars (\$1,000.00) unless the Trainer was not notified of the first offense prior to the horse running the second time, in which case the Stewards shall impose a fine of Five Hundred Dollars (\$500.00). The Stewards shall impose a fine of Two Thousand Five Hundred Dollars (\$2,500.00) and may suspend for up to one year the license of any person for a third time violation within a one (1) year period of this Section involving the same horse. When a Trainer has a third violation within a one (1) year period, the horse shall be disqualified and the Owner or Owners of such horse shall not participate in any portion of the purse or stakes; and any trophy or other award shall be returned unless the Trainer was not notified of the second offense prior to the horse running the third time, in which case the Stewards shall impose a fine of Two Thousand, Five Hundred Dollars (\$2,500.00).

Permanent Final Adoptions

325:45-1-28. Report of treatment: Procaine Penicillin administration

The efficacious nature of Procaine Penicillin shall permit its use as a therapeutic medication. A licensed trainer or his veterinarian shall submit, prior to post time of the first race on the day of the race, a report to the Official Veterinarian that the horse participating on that day's race card has been previously treated with a Procaine Penicillin administration. The report must contain the Procaine Penicillin administration, treatment dates, dosage, name and tattoo number of the horse, Trainer's name and race date. The presence of Procaine Penicillin in the post race sample of a participating horse is permitted under the following conditions:

- (1) Report of treatment is properly filed with the Official Veterinarian.
- (2) The treated horse is presented, prior to the first race, to the Official Veterinarian in order to draw an adequate blood sample for testing.
- (3) The pre-race blood/serum sample shall be tested and compared to the post-race blood/serum sample. The pre-race sample shall not exceed the Commission-sanctioned levels for thresholds. Should the pre-race sample levels be reported by the official testing laboratory as equal to or greater than the post-race levels, there shall be no positive affidavit filed by the laboratory.
- (4) Should the post-race sample levels exceed the pre-race levels by an amount not sanctioned by the Commission, the sample shall be treated as being in violation of the rules of this Chapter. A positive affidavit will be issued by the laboratory. The Stewards may use mitigating factors in their decision to impose disciplinary action against the Trainer, horse or other parties found to have been in violation of this Chapter. The cost of pre-race testing shall be the responsibility of the Owner of the treated horse.

[OAR Docket #07-650; filed 4-3-07]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 60. RUNNING THE RACE

[OAR Docket #07-651]

RULEMAKING ACTION:
PERMANENT final adoption

RULE:
325:60-1-12. Display of colors and post position numbers [AMENDED]

AUTHORITY:
75 Oklahoma Statutes §§302, 305, and 307; Title 3A O.S., §204(A); Oklahoma Horse Racing Commission

DATES:
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SUPERSEDED EMERGENCY ACTIONS:
Not Applicable

INCORPORATED BY REFERENCE:
Not Applicable

ANALYSIS:
Amendment to Rule 325:60-1-12 was proposed because helmet covers are part of the owner's colors and this rule as noted deprives them of full use of their colors. It merely eliminates the requirement that helmet cover must correspond to the saddle towel.

CONTACT PERSON:
Bonnie Morris, Assistant to the Administrator, Oklahoma Horse Racing Commission, Shepherd Mall, 2614 Villa Prom, Oklahoma City, OK 73107, (405) 943-6472

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULE IS CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

325:60-1-12. Display of colors and post position numbers

Any Owner or racing stable may; register a set of racing colors following the standard style and material to be used in any race in which a horse or horses owned by them may be participating. All racing colors must be registered with the Racing Secretary's Office no later than entry time for the race in question. Any Owner who has registered such colors shall present them in a clean and neat condition. Any Owner who does not register a set of racing colors shall use standard post position racing colors furnished by the organization licensee. ~~All helmet cover colors shall correspond to post position colors regardless of the wearing of Owner's colors.~~ In a race, each horse shall carry a conspicuous saddle cloth number and a head number; ~~and the Jockey shall wear a helmet cover corresponding to the number of the horse.~~ In the event of the use of standard post position racing colors, the helmet cover shall correspond to the standard post position colors furnished by the organization licensee.

[OAR Docket #07-651; filed 4-3-07]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 75. OKLAHOMA-BRED PROGRAM

[OAR Docket #07-652]

RULEMAKING ACTION:
PERMANENT final adoption

RULE:
325:75-1-7. Registration required for Oklahoma-Bred eligibility [AMENDED]
325:75-1-9. Decision as to eligibility of Oklahoma-Bred [AMENDED]
AUTHORITY:
75 Oklahoma Statutes §§302, 305, and 307; Title 3A O.S., §204(A); Oklahoma Horse Racing Commission
DATES:
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SUPERSEDED EMERGENCY ACTIONS:
Not Applicable
INCORPORATED BY REFERENCE:
Not Applicable
ANALYSIS:

Amendment to both Rule 325:75-1-7 and 325:75-1-9 eliminates the requirement of a signed affidavit being provided before an Oklahoma-Bred payment was issued with the affidavit verifying that the horse involved complies with the requirements for a purse supplement, stake reward or broodmare or stallion award. This requirement was eliminated with statutory amendment to Section 208.3, Oklahoma Breeding Development Special Account through the passage of SB 1399, which took effect June 7, 2006.

CONTACT PERSON:
Bonnie Morris, Assistant to the Administrator, Oklahoma Horse Racing Commission, Shepherd Mall, 2614 Villa Prom, Oklahoma City, OK 73107, (405) 943-6472

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

325:75-1-7. Registration required for Oklahoma-Bred eligibility

Unless the breeder or owner of an Oklahoma-Bred racing stock has registered the horse with the official Oklahoma-Bred Registering Agency and attested that the horse is an Oklahoma-Bred, and unless the horse's Certificate of Registration which is on file with the applicable racetrack is stamped with the official Oklahoma-Bred Program stamp such horse is ineligible to start in races for Oklahoma-Bred horses and ineligible for Oklahoma-Bred purse supplements. Unless the owner of an Oklahoma-Bred stallion or broodmare has registered the horse with the official Oklahoma-Bred Registering Agency and attested that the horse is an Oklahoma-Bred such horse is ineligible for Oklahoma-Bred stallion or broodmare awards. ~~Any person entitled to monies from the Oklahoma Breeding~~

~~Development Fund Special Account as a purse supplement, stake, reward, or award, prior to receiving said monies, shall sign an affidavit stating that the horse involved complies with the requirements for the purse supplement, stake, reward, or award. [3A:208.3] The Registering Agency will verify the current eligibility of a participating horse prior to distributing any purse supplement, stake, reward or award from the Oklahoma Breeding Development Fund Special Account.~~

325:75-1-9. Decision as to eligibility of Oklahoma-Bred

Questions as to the registration, eligibility for registration, or breeding of an Oklahoma-Bred horse shall be decided by the official Registering Agency designated by the Commission. The official Registering Agency may demand and inspect any Registration Certificate or record of an Oklahoma breeder, and shall ~~require affidavits in support of any claim for Oklahoma-Bred registration~~ verify that the horse involved complies with the requirements for the purse supplement, stake, reward or award. Concerning questions as to parentage, the official Registering Agency may require blood-typing of the horse in question, as well as its sire and dam. Such blood-typing shall be done by an organization approved by the official Registering Agency. The results of this test may be taken into consideration by the official Registering Agency in its determination of the horse's parentage. When a person has been suspended from participation in the Oklahoma-Bred Program, any other ownership entity in which such person may have ownership interest shall also be ineligible for added purse supplements and any broodmare or stallion awards from the Oklahoma-Bred Program; and any horse owned by such entity shall be ineligible for registration or participation in the Oklahoma-Bred Program for the same period of time as designated in such person's suspension. A decision of the official Registering Agency shall be subject to review by the Commission, which retains the right to make the final decision as to any right or liability under this Chapter.

[OAR Docket #07-652; filed 4-3-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 1. FUNCTION AND STRUCTURE OF THE DEPARTMENT**

[OAR Docket #07-556]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 1. General Provisions
340:1-1-17 [AMENDED]
340:1-1-21 [AMENDED]
(Reference APA WF 06-22)

AUTHORITY:
Commission for Human Services, Article XXV, Sections 2, 3, and 4 of the Oklahoma Constitution; Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; and Sections 250 et seq. of Title 75 of the Oklahoma Statutes.

Permanent Final Adoptions

DATES:

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n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Chapter 1 rule revisions reflect current: (1) names of offices within the Oklahoma Department of Human Services (OKDHS); and (2) OKDHS form numbers.

CONTACT PERSON:

Dena Thayer, Programs Manager, Policy Management Unit, DHS, 2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-3611.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

340:1-1-17. Organizational structure

(a) **Commission for Human Services (Commission).** The Oklahoma Department of Human Services (OKDHS) is governed by a nine-member Commission. Each Commissioner is appointed by the Governor of Oklahoma to serve a nine-year term. The Commission selects a Director of Human Services (Director) who is responsible for oversight of OKDHS.

(b) **Organizational chart.** OKDHS is organized as the Director and Commission deem desirable to carry out the OKDHS mission. Organizational charts are available upon request to the Office of Administrative Services.

(c) **Offices and divisions within the OKDHS.** The functions of the offices and divisions within OKDHS are outlined in this subsection.

(1) ~~Office of Administrative Services.~~ The chief administrative officer serves as coordinator of the administrative divisions within OKDHS and provides oversight of divisions that report directly to the Director. Administrative divisions under the ~~Office of Administrative Services~~ are:

(A) Human Resources Management Division (HRMD);

(B) ~~Office Support Services Division (OSSD SSD);~~

(C) Office of Communications;

~~(D) Office of Planning, Policy, and Research (OPPR);~~

~~(E) Office of Volunteerism;~~

~~(F) Office of Information and Referral;~~

~~(G) Office of Legislative Relations and Special Projects Policy (OLRP); and~~

~~(H) the divisions responsible for the functions that report directly to the Director, which are:~~

(i) Office of Client Advocacy;

(ii) Office of Inspector General; and

(iii) Office for Civil Rights.

(2) **Legal Division.** The general counsel serves as the coordinator of the Legal Division and as chief legal counsel to the Commission and the Director.

(3) **Human Services Centers.** The chief operating officer serves as coordinator of services delivered through offices in each county. Divisions within the Human Services Centers are:

(A) Family Support Services Division (FSSD);

(B) Children and Family Services Division (CFSD); and

(C) Field Operations Division (FOD).

(4) ~~Information technology Services Divisions.~~ The chief information officer serves as coordinator of ~~the Data Services Division and is responsible for coordination of~~ OKDHS information technology. Divisions and offices within information services are:

(A) Data Services Division (DSD);

(B) Office of Planning, Research, and Statistics (OPRS);

(C) Enterprise Project Management Office; and

(D) Information Security.

(5) **Financial services.** The chief financial officer serves as coordinator of the Finance Division and is responsible for the coordination of OKDHS financial services.

(6) ~~Vertically integrated services~~ **Integrated Services Divisions.** The chief coordinating officer serves as coordinator of program divisions, which have vertically integrated administrations. For example, field staff and ~~programs~~ program design staff are under the same administrative structure. Divisions included in the vertically integrated services are:

(A) Aging Services Division (ASD);

(B) Division of Child Care (DCC);

(C) Child Support Enforcement Division (CSED); and

(D) Development Disabilities Services Division (DDSD).

340:1-1-21. Copyrighted software and documents

(a) Oklahoma Department of Human Services (OKDHS) employees:

- (1) sign Form ~~ADM-133~~ 11AD133E, Employee Acknowledgment of Confidentiality of Computer Accessible Case Records and Computer and Internet Usage Restrictions;
 - (2) comply with the terms and conditions regarding the copyrights of all vendors with whom OKDHS enters into software license agreements or from whom OKDHS purchases software; and
 - (3) may not reproduce software or its related documentation unless authorized by the software developer.
- (b) OKDHS employees adhere to copyright laws. Copyrighted documents are not reproduced without written permission from the copyright source.

[OAR Docket #07-556; filed 3-28-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 2. ADMINISTRATIVE COMPONENTS**

[OAR Docket #07-557]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. Human Resources Management Division (HRMD)

Part 3. Internal Human Resources

340:2-1-32 [AMENDED]

(Reference APA WF 06-10)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2, 3, and 4 of the Oklahoma Constitution; and Section 7004-1.8 of Title 10 of the Oklahoma Statutes.

DATES:

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December 15, 2006 through January 16, 2007

Public hearing:

None requested

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Superseded rules:

Subchapter 1. Human Resources Management Division (HRMD)

Part 3. Internal Human Resources

340:2-1-32. [AMENDED]

(Reference APA WF 06-10)

Gubernatorial approval:

November 1, 2006

Register publication:

24 Ok Reg 342

Docket number:

06-1441

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Human Resources Management Division (HRMD) rule revisions: (1) bring the rule into compliance with Section 7004-1.8 of Title 10 of the Oklahoma Statutes (O.S.), by establishing a performance-based incentive compensation program for full-time Child Welfare specialists, levels I through IV, who meet the requirements.

CONTACT PERSON:

Dena Thayer, Programs Manager, Policy Management Unit, OKDHS, 2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-3611.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. HUMAN RESOURCES MANAGEMENT DIVISION (HRMD)

PART 3. INTERNAL HUMAN RESOURCES

340:2-1-32. Salary Administration Plan (SAP) and Agency Compensation Guidelines

(a) **Salary Administration Plan (SAP).** The ~~Salary Administration Plan (SAP)~~ is based on the standard that employees performing similar work receive similar pay and that variation in the requirements is reflected equitably in the pay band. The salary range established for each job family and level provides a minimum and maximum salary rate.

(1) **Computation of salary payments — general.**

Oklahoma Department of Human Services (OKDHS) employees are paid on a monthly basis in accordance with applicable salary schedules. The pay period extends from the 16th of the month through the 15th of the following month.

(2) **Entrance salary.**

The entrance salary for positions in the classified service is the entry salary identified in the SAP, except as provided in the Merit System of Personnel Administration Rules (Merit Rules). The entrance salary for positions in the unclassified service is normally a comparable salary. Requests to establish salary above the minimum may be processed by completing Form 11PE017E, Salary Exception Request, in accordance with the Special Entrance Rate/Salary Exception Process (P-17) special entrance rate or salary exception request (ACG). The salary of a new employee is effective on the employee's first working day.

(3) **Salary increase.** Salary increases are not automatic but are granted in accordance with the SAP and applicable legislation.

(4) **Equity and salary adjustments.** For classified employees, an equity pay adjustment is a mechanism authorized in accordance with appropriate Merit Rules

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and the ~~Agency Compensation Guidelines~~ ACG. For employees in the unclassified service, a change in salary is in accordance with the ~~Agency Compensation Guidelines~~ ACG or applicable legislation.

(b) Performance-based incentive compensation program. A person employed full-time as Child Welfare (CW) specialist I through IV, exclusively working as a CW specialist, may be eligible once per year for the performance-based incentive compensation program authorized by Section 7004-1.8 of Title 10 of the Oklahoma Statutes.

(1) Incentive compensation. The incentive compensation is a lump sum performance incentive of one and one-half percent of the established annual base salary of the eligible employee. The lump sum incentive compensation does not increase the base salary of the employee.

(2) Requirements. To be eligible for the incentive compensation, the employee must meet the criteria included in (A) or (B) of this paragraph.

(A) Master-level employees must:

(i) have an overall rating of exceeds standards on the most recent completed Form OPM-111, Performance Management Process (PMP);

(ii) have a master's degree, from an institution accredited by a generally accepted accrediting body and accepted for transfer credit by the Oklahoma Regents for Higher Education, in:

- (I) social work;**
- (II) human relations;**
- (III) psychology;**
- (IV) sociology;**
- (V) guidance and counseling;**
- (VI) juvenile justice; or**
- (VII) child development;**

(iii) have completed all required OKDHS sponsored field training per OAC 340:75-1-231 and 340:75-1-232; and

(iv) be assigned to the same human services center for 12 consecutive months on the day of the employee's annual performance review.

(B) Employees in counties who meet the OKDHS Child and Family Services Review (CFSR) standards must:

(i) have an overall rating of meets standards on the most recent completed Form OPM-111;

(ii) have completed all required OKDHS sponsored field training per OAC 340:75-1-231 and 340:75-1-232; and

(iii) be assigned to the same human services center for 12 consecutive months on the date of the CFSR per OAC 340:75-18-10.

(I) The human services center must meet or exceed all current federal standards for outcomes in safety, permanency, and well-being by children and families.

(II) The CFSR is completed yearly by OKDHS utilizing current CFSR national standards as adopted by the Administration for Children and Family Services of the United

States Department of Health and Human Services pursuant to Sections 1355.31 through 1355.37 of Title 45 of the Code of Federal Regulations, as amended.

[OAR Docket #07-557; filed 3-28-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 2. ADMINISTRATIVE COMPONENTS

[OAR Docket #07-558]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Office Of Client Advocacy

Part 1. Administration

340:2-3-2 [AMENDED]

Part 3. Investigations

340:2-3-33 through 340:2-3-38 [AMENDED]

Part 5. Grievances

340:2-3-45 through 340:2-3-53 [AMENDED]

340:2-3-55 [AMENDED]

Part 7. Grievance and Abuse Review Committee

340:2-3-64 [AMENDED]

Part 9. Ombudsman Programs

340:2-3-73 through 340:2-3-74 [AMENDED]

(Reference APA WF 06-17)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; Sections 10-101 through 10-111 of Title 43A of the Oklahoma Statutes (O.S.); and Sections 175.20 and 601.6 of Title 10 O.S.

DATES:

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Public hearing:

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n/a

INCORPORATIONS BY REFERENCE:

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ANALYSIS:

Office of Client Advocacy (OCA) rule revisions: (1) clarify definitions; (2) correct citations; (3) remove ambiguities; (4) clarify the differences between reporting and referring to OCA; (5) clarify that OCA serves the foster care program of the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division; (6) clarify the title of the OCA grievance liaison; (7) clarify the local grievance coordinator (LGC) process; (8) clarify the foster parent grievance process to allow for mediation; and (9) insert new OKDHS form numbers.

CONTACT PERSON:

Dena Thayer, Programs Manager, Policy Management Unit, OKDHS, 2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-3611.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2007:

SUBCHAPTER 3. OFFICE OF CLIENT ADVOCACY

PART 1. ADMINISTRATION

340:2-3-2. Definitions

The following words and terms when used in this Subchapter shall have the following meanings, unless the context clearly indicates otherwise.

"Abuse" means, with regard to:

(A) minors and youth, the causing or permitting harm or threatened harm to the health, safety, or welfare of the minor or youth by a caretaker responsible for the minor's or youth's health, safety, or welfare, including but not limited to sexual abuse, sexual exploitation, and the intentional use of excessive or unauthorized force aimed at hurting or injuring the minor or youth; or

(B) vulnerable adults, abuse as defined by Section 10-103(8) of Title 43A of the Oklahoma Statutes.

"Administrator," including the person designated by an administrator to act on the administrator's behalf, means, with regard to:

(A) minors in Oklahoma Department of Human Services (OKDHS) custody living in a private residential facility, the chief administrative officer of the facility;

(B) minors in OKDHS custody in an OKDHS operated shelter or group home, the director of the shelter or group home;

(C) minors in OKDHS custody and youth in voluntary care of OKDHS who live in any other setting, including any type of out-of-home placement, the applicable OKDHS county director;

(D) foster parents, the applicable OKDHS county director or area director, as appropriate;

(E) minors and youth in residential care facilities operated by Office of Juvenile Affairs (OJA) or Department of Rehabilitation Services (DRS), facilities which contract with or are licensed by OJA, Department of Mental Health and Substance Abuse Services (DMHSAS), the J.D. McCarty Center, or OKDHS, and other residential care facilities, the superintendent, director, chief administrative officer, or head of the facility regardless of the person's working title;

(F) day treatment programs, the person charged with responsibility for administering the program;

(G) adults and minors who are in Developmental Disabilities Services Division (DDSD) specialized foster care and DDSD specialized foster parents, the applicable DDSD area manager;

(H) residents of Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Greer Center Facility (Greer), the facility director;

(I) providers of residential services, vocational services, or in-home paraprofessional supports to individuals with developmental disabilities living in the community, the chief executive officer of the provider; and

(J) residents of group homes for persons with developmental disabilities, the director of the group home.

"Adult Protective Services" or "APS" means the Adult Protective Services Unit of OKDHS.

"Advocate," also known as "ombudsman" or "ombuds," means an Office of Client Advocacy (OCA) employee who provides assistance to OCA clients in exercising their rights, listening to their concerns, encouraging them to speak for themselves, seeking to resolve problems, helping protect their rights, and seeking to improve the quality of their life and care.

"Advocate general" means the chief administrative officer of the OCA designated in Section 7004-3.4(B)(1) of Title 10 of the Oklahoma Statutes. The e-mail address for the advocate general is *OCA.advocategeneral@okdhs.org.

"Authorized use of physical force" by a caretaker of minors and youths residing outside their homes, other than minors and youth in foster care means:

(A) means the use of physical contact to control or contain a person when the caretaker reasonably considers that person to:

- (i) pose a risk of inflicting harm to self or others; or
(ii) be in the process of leaving a facility without authorization; and

(B) When when the use of physical force is authorized, the least force necessary under the circumstances is employed. In determining whether excessive force has been used, all of the circumstances surrounding the incident are taken into consideration, including:

- (i) the grounds for belief that force was necessary;
(ii) the age, gender, and strength of the parties involved;
(iii) the nature of the force employed;
(iv) the availability of alternative means of force or control; and
(v) the extent of the harm inflicted.

"Caretaker" means, with regard to:

(A) minors and youth, an agent or employee of:

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(i) a public or private residential home, institution, or facility above the level of foster family care; or

(ii) a day treatment program as defined in Section 175.20 of Title 10 of the Oklahoma Statutes; and

(B) vulnerable adults, caretaker as defined in Section 10-103(6) of Title 43A of the Oklahoma Statutes.

"Caretaker misconduct":

(A) means an act or omission that:

(i) violates a statute, regulation, written rule, procedure, directive, or accepted professional standards and practices;

(ii) is not found to be abuse or neglect; and

(iii) results in or creates the risk of harm to a minor or vulnerable adult.

(B) includes, but is not limited to:

(i) acts or omissions that contribute to the delinquency of a minor;

(ii) unintentional excessive or unauthorized use of force not rising to abuse or neglect;

(iii) unintentionally causing mental anguish;

(iv) other acts exposing a client to harm or threatened harm to the health, safety or welfare of the client; or

(v) use of abusive or professionally inappropriate language not rising to the level of verbal abuse.

"**Case manager**" means the person assigned by DDSD who has the responsibility for ensuring that services to an individual are planned and provided in a coordinated fashion.

"**Child placing agency**" means an agency that provides social services to children and their families that supplement, support, or substitute parental care and supervision for the purpose of safeguarding and promoting the welfare of children. The agency may provide full time placement services for children away from their own homes, such as adoptive homes, foster family homes, group homes, and transitional or independent living programs.

"**Client**" means, with regard to:

(A) OCA's investigation services, those individuals listed in OAC 340:2-3-32(a)(2);

(B) OCA's grievance services, those individuals listed in OAC 340:2-3-45(a)(2); and

(C) OCA's ombudsman program, those individuals listed in OAC 340:2-3-71(b).

"**Community services worker**" or "**CSW**" means any person not a licensed health professional who is employed by or under contract with a community services provider to provide, for compensation or as a volunteer, health-related services, training, or supportive assistance as those terms are defined in Section 1025.1 of Title 56 of the Oklahoma Statutes.

"**Community Services Worker Registry**" or "**CSW Registry**" means the Community Services Worker Registry established by OKDHS in accordance with Section 1025.3 of Title 56 of the Oklahoma Statutes.

"**Day treatment program**" means a non-residential, partial hospitalization program, day treatment program, or

day hospital program in which minors are provided intensive services, psychiatric, or psychological treatment.

"**DDSD**" means the Developmental Disabilities Services Division of OKDHS.

"**DHS**" or "**Department**" or "**OKDHS**" means the Oklahoma Department of Human Services.

"**Disposition**", with regard to OCA's intake processes, means the action taken by OCA intake in response to a referral received, pursuant to OAC 340:2-3-35.

"**DMHSAS**" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"**DRS**" means the Oklahoma Department of Rehabilitation Services.

"**E-mail**" means:

(A) with regard to the advocate general, an e-mail sent to *oca.advocategeneral@okdhs.org;

(B) with regard to OCA grievance matters, an e-mail sent to *oca.grievances@okdhs.org;

(C) with regard to OCA investigation matters, an e-mail sent to *oca.investigations@okdhs.org; and

(D) with regard to OCA intake matters, *oca.intake@okdhs.org.

"**Emergency**" means a situation in which a person is likely to suffer death or serious physical harm without immediate intervention.

"**Excessive use of force**" by a caretaker, with regard to minors and youths residing outside their homes, other than minors and youth in foster care, means the failure to employ the least amount of physical force necessary under the circumstances, taking into consideration all of the circumstances surrounding the incident, including:

(A) the grounds for belief that force was necessary;

(B) the age, gender, and strength of the parties involved;

(C) the nature of the force employed;

(D) the availability of alternative means of force or control;

(E) the extent of the harm inflicted; and

(F) the method(s) of restraint and intervention approved for use with the person against whom the force was used.

"**Exploitation**" or "**exploit**" with regard to vulnerable adults, means exploitation or exploit as defined in Section 10-103(9) of Title 43A of the Oklahoma Statutes.

"**Facility**" means:

(A) a public or private agency, corporation, partnership, or other entity which:

(i) operates a residential child care center; or

(ii) contracts with or is licensed or funded by OKDHS, OJA, or DMHSAS for the physical custody, detention, or treatment of minors;

(B) an OKDHS operated shelter;

(C) an OKDHS, OJA, DMHSAS, or DRS operated residential child care center;

(D) a community-based youth services shelter or community intervention center;

(E) the J.D. McCarty Center;

(F) a day treatment program;

- (G) a private psychiatric facility for minors;
- (H) sanctions programs certified by OJA to provide programming for minors who are court ordered to participate in that program; or
- (I) SORC, NORCE, and Greer.

"Foster care" or **"foster care services"** means continuous 24-hour care and supportive services provided for ~~a child~~ an individual in a foster placement, including but not limited to the care, supervision, guidance, and rearing of a foster child by the foster parent.

"Foster child" means a child placed in a foster family placement.

"Foster parent" means an individual maintaining a foster family home who is responsible for the care, supervision, guidance, rearing, and other foster care services provided to ~~a foster child~~ another individual.

"GARC" means the Grievance and Abuse Review Committee described in OAC 340:2-3-61.

"Guardian" means a person appointed by a court to ensure that the essential requirements for the health and safety of an incapacitated or partially incapacitated person, the ward, are met, to manage the estate or financial resources of the ward, or both. As used in this Subchapter, guardian includes: a general or limited guardian of the person; a general or limited guardian of the estate; a special guardian; and a temporary guardian. The term does not include a person appointed as guardian ad litem.

"Guardian ad litem" or **"GAL"** means a person appointed by a court, pursuant to Section 1415 of Title 10 of the Oklahoma Statutes, to represent the interests of an individual as specified in the court order.

"Harm or threatened harm to the health, safety, or welfare" includes but is not limited to:

- (A) non-accidental physical injury or mental anguish;
- (B) sexual abuse;
- (C) sexual exploitation;
- (D) failure to provide protection from harm or threatened harm;
- (E) the unauthorized use of force; or
- (F) the use of excessive force.

"Hissom class member" means an individual certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound, et al. vs. The Hissom Memorial Center, et al.*, Case No. 85-C-437-E.

"Hotline" means the statewide, toll free hotline, 1-800-522-3511, maintained by OKDHS for the purpose of receiving reports of abuse, neglect, or exploitation of children and adults. The hotline is in operation 24 hours a day, 7 days a week.

"ICF/MR" or **"Intermediate Care Facility for the Mentally Retarded,"** also known as a "specialized facility for the mentally retarded," means a private or public residential facility, licensed in accordance with state law and certified by the federal government as a provider of Medicaid services, for mentally retarded persons as that term is defined in Title XIX rules and regulations of the Social Security Act.

"Incapacitated person" means:

(A) any person 18 years of age or older who is impaired by reason of mental or physical illness or disability, dementia, or related disease, mental retardation, developmental disability, or other cause, and whose ability to receive and evaluate information effectively or to make and to communicate responsible decisions is impaired to such an extent that the person lacks the capacity to manage financial resources or to meet essential requirements for mental or physical health or safety without assistance from others; or

(B) a person for whom a guardian, limited guardian, or conservator has been appointed pursuant to the Oklahoma Guardianship and Conservatorship Act, Title 30 of the Oklahoma Statutes.

"Indecent exposure" means indecent exposure as defined by Section 10-103(12) of Title 43A of the Oklahoma Statutes.

"In-home supports" and **"IHS"** means services funded through Medicaid Home and Community-Based Waivers (HCBW) as defined in Section 1915(c) of the Social Security Act and administered by OKDHS DDS, which are provided in the service recipient's home and are not residential services as defined in OAC 340:100-5-22.1 or group home services as defined in Title 10, Section ~~1430~~ 1430.2 of the Oklahoma Statutes.

"Injury" means any hurt, harm, appreciable physical pain, or mental anguish.

"Maltreatment" is used collectively in this Subchapter to refer to abuse, neglect, verbal abuse, exploitation, caretaker misconduct, sexual abuse, and sexual exploitation as defined in this Section.

"Medicaid personal care assistant" or **"MPCA"** means a person who provides Medicaid services funded under Oklahoma's personal care program who is not a certified nurse aide or a licensed professional.

"Mental anguish" means mental damage evidenced by distress, depression, withdrawal, severe anxiety, or unusually aggressive behavior toward self or others.

"Minor" means any person under the age of 18 years except any person convicted of a crime specified in Section 7306-1.1 of Title 10 of the Oklahoma Statutes or any person certified as an adult pursuant to Section 7303-4.3 of Title 10 and convicted of a felony.

"Minor physical injury" means a demonstrable injury reasonably expected to be treated with the administration of first aid, over the counter remedies, or both. A demonstrable injury includes damage to bodily tissue caused by non-therapeutic conduct, illness, new or an increased impairment of physical or cognitive functioning, evidence of a physical injury (for example, a laceration, bruise, or burn, ~~or fracture~~), and an injury which is confirmed by a physician, dentist, nurse, or other health care professional.

"Neglect" means, with regard to:

- (A) minors and youth, the failure of a caretaker to provide:
 - (i) adequate food, clothing, shelter, medical care, or supervision which includes, but is not

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limited to, lack of appropriate supervision which results in sexual activity between minors; or

(ii) special care made necessary by the physical or mental condition of the minor or youth; or

(B) vulnerable adults, neglect as defined in Section 10-103(10) of Title 43A of the Oklahoma Statutes.

"OCA" means the Office of Client Advocacy of OKDHS.

"OCA intake" means the centralized intake system maintained by OCA in its Oklahoma City office that receives referrals of alleged abuse, neglect, verbal abuse, and financial exploitation.

"OJA" means the Oklahoma Office of Juvenile Affairs.

"Ombudsman" or **"ombuds,"** means "advocate" as defined in this subsection.

"Personal support team" or **"team,"** formerly known as the "interdisciplinary team," means the decision-making body for service planning, implementation, and monitoring of the individual plan, as more fully described in OAC 340:100-5-52.

"Preponderance of the evidence" means information or evidence that is of a greater weight or more convincing than the information or evidence offered in opposition. It is that degree of proof which is more probable than not.

"Problem resolution" means verbal or written communications which seek to resolve concerns, complaints, service inadequacies, or issues identified by the client or members of the client's team, including the client's guardian, the OCA advocate for the client, a volunteer advocate for the client, or other persons interested in the welfare of the client.

"Provider" means a program, corporation, partnership, association, individual, or other entity that contracts with, or is licensed or funded by, OKDHS to provide community-based residential or vocational services to persons with mental retardation or developmental disabilities, or which contracts with the Oklahoma Health Care Authority to provide residential or vocational services or in-home supports to individuals with mental retardation through the Home and Community-Based Waiver.

"Referring party" means the individual who informs OCA verbally or in writing that an incident occurred.

"Reporting party" means the individual who initially tells someone verbally or in writing that an incident occurred.

"Residential child care center" means a 24-hour-a-day residential group care facility at which a specified number of minors, normally unrelated, reside with adults other than their parents.

"Self-neglect" means self-neglect as defined in Section 10-103(13) of Title 43A of the Oklahoma Statutes.

"Serious physical injury" means a physical injury to a person's body determined to be serious by a physician, dentist, or nurse. It includes, but is not limited to, death, suicide attempt, fracture, dislocation of any major joint, internal injury, concussion, head injury with loss of consciousness, ingestion of foreign substances and objects that are harmful; near drowning, lacerations involving injuries to tendons or organs and those for which complications are present, lacerations requiring four or more stitches or staples to close, heat exhaustion or heatstroke, injury to an eyeball, irreversible loss of mobility,

permanent damage to or loss of a tooth, skin deterioration, and a second or third degree burn and other burns for which complications are present. It also includes multiple abrasions, bruises, and minor physical injuries on the body of a person, identified around the same time or over a period of several weeks, that have no clear, known explanation.

"Sexual abuse" means, with regard to:

(A) minors and youth, rape, incest, and lewd or indecent acts or proposals, as defined by state law, by a caretaker responsible for the health, safety, or welfare of the minor or youth; or

(B) vulnerable adults, sexual abuse as defined by Section 10-103(11) of Title 43A of the Oklahoma Statutes.

"Sexual exploitation" means, with regard to:

(A) minors and youth:

(i) allowing, permitting, or encouraging a minor or youth to engage in sexual acts with others or prostitution, as defined by state law, by a caretaker responsible for the minor's or youth's health, safety, or welfare; or

(ii) allowing, permitting, encouraging, or engaging in the lewd, obscene, or pornographic photographing, filming, or depicting of a minor or youth in those acts as defined by the state law, by a caretaker responsible for the minor's health, safety, or welfare; or

(B) vulnerable adults, sexual exploitation as defined by Section 10-103(14) of Title 43A of the Oklahoma Statutes.

"Specialized foster care" means foster care provided to a minor or adult in a specialized foster home or agency-contracted home which has been certified by DDS, is monitored by DDS, and is funded through the Home and Community-Based Waiver Services Program administered by DDS.

"State office" means the administrative offices of OKDHS in Oklahoma City.

"State office administrator," including the person designated by a state office administrator to act on the state office administrator's behalf, means, with regard to:

(A) grievances of minors, youths, and foster parents regarding the substance or application of any policy, rule, or regulation, written or unwritten, of OKDHS or an OKDHS operated shelter or residential facility, or of an agent or contractor of OKDHS, or a child placement agency, the director of OKDHS Children and Family Services Division (CFSD);

(B) grievances regarding a decision, behavior, or action by an OKDHS employee, agent, contractor, foster parent, or by any person residing in the same placement setting, the director of the OKDHS Field Operations Division;

(C) DDS clients, the director of DDS; and

(D) other OKDHS clients, the appropriate chief officer or division director.

"Subpoena" means a command to appear at a certain time and place to give testimony. A "subpoena duces tecum" is

a command requiring the person subpoenaed to bring records with them.

"Suspicious injury" means an injury for which there is no credible explanation that makes it unlikely to be the result of client maltreatment.

- (A) It includes but is not limited to an injury that:
- (i) appears inconsistent with the offered explanation(s) for the injury;
 - (ii) is unusual;
 - (iii) cannot be explained as the result of an accident, self-injurious behavior or normal activities of daily living;
 - (iv) is a minor injury located on or near a private part of the body or on a part of the body that makes it unlikely to have been the result of self-injury or an accident during the course of daily living activities; and
 - (v) involves multiple abrasions, bruises, and minor injuries on the body of a person, identified around the same time or over a period of several weeks, ~~which are unlikely to be the result of normal daily living activities but have no clear, known explanation.~~

(B) The determination whether an injury is suspicious is made from the point of view of an independent skeptical reviewer. An injury is suspicious if there is no credible explanation for it consistent with the injury not being the result of maltreatment.

"Unauthorized use of force" means, with regard to minors and youths residing outside their homes, other than minors and youth in foster care, a use of force that is not an authorized use of physical force as defined in this subsection. It includes unacceptable physical handling of and contact with clients including, but not limited to, slapping, kicking, punching, poking, pulling hair or an ear, pinching, using a choke hold, smothering, spitting, head butting, and tugging.

"Unexplained injury" means an injury for which there is no known credible origin or cause, even though a possible explanation for the injury may be offered.

"Verbal abuse" means verbal abuse as defined in Section 10-103(15) of Title 43A of the Oklahoma Statutes.

"Vulnerable adult" means vulnerable adult as defined by Section 10-103(5) of Title 43A of the Oklahoma Statutes.

"Ward" means a person over whom a guardianship has been given by the court.

"Youth" means, with regard to:

- (A) OCA's investigation programs, a person over the age of 18 in OJA custody and residing in an OJA operated facility or a facility which contracts with OJA; or
- (B) OCA's grievance programs, a person over the age of 18 in OJA custody or voluntary care of OKDHS.

PART 3. INVESTIGATIONS

340:2-3-33. Procedure for reporting suspected abuse, neglect, verbal abuse, caretaker misconduct, and exploitation

(a) **Reporting requirements and reportable incidents.**

(1) Persons having reason to believe that a minor is a victim of abuse or neglect are required by Section 7103 of Title 10 of the Oklahoma Statutes to promptly report it to the Oklahoma Department of Human Services (OKDHS).

(2) Persons having reason to believe that a vulnerable adult is a victim of abuse, neglect, verbal abuse, or exploitation are required by Section 10-104 of Title 43A of the Oklahoma Statutes to promptly report it to OKDHS. This reporting requirement applies to providers, as defined in OAC 340:2-3-2, and their employees and agents.

(3) In addition, employees of OKDHS, Department of Rehabilitation Services (DRS), Department of Mental Health and Substance Abuse Services (DMHSAS), Office of Juvenile Affairs (OJA), and the J.D. McCarty Center who have reason to believe that caretaker misconduct, as defined in OAC 340:2-3-2, with regard to a client has occurred promptly ~~report~~ refer it to OCA intake. This ~~reporting~~ referring requirement also extends to employees of private facilities that contract with OKDHS, DRS, DMHSAS, and OJA to provide residential services to these clients.

(4) A person can have reason to believe that maltreatment has occurred based on information ~~they have~~ he or she has learned directly or indirectly, including information provided by the alleged victim or witnesses to an incident. When an allegation of maltreatment is made by the alleged victim or the guardian or parent of the alleged victim, it is ~~reported~~ referred to OCA intake. Persons unsure of what to report or to refer call OCA intake, 1-800-522-8014, during business hours, and after hours call the Abuse Hotline, 1-800-522-3511.

(5) Knowledge of circumstances which may constitute maltreatment is reported even if the person reporting it cannot substantiate the information.

(6) In addition to the reportable incidents in paragraphs (1), (2), and (3) of this subsection, employees and agents of OKDHS, DRS, DMHSAS, OJA, the J.D. McCarty Center, facilities, and providers report to OCA events listed in (A) through (G) of this paragraph involving a person listed in OAC 340:2-3-32(a)(2):

- (A) a violent death, whether apparently homicidal, suicidal, or accidental;
- (B) a death under suspicious, unusual, or unnatural circumstances;
- (C) the death of a resident of the Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Greer Center Facility (Greer);
- (D) the death of a Hissom class member;
- (E) a serious physical injury, as defined in OAC 340:2-3-2;
- (F) any physical injury if it is:
 - (i) unexplained; and
 - (ii) suspicious; or

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- (G) rape, sodomy, or other sexual activity prohibited by state law.
- (7) "Promptly" reporting as used in this Subchapter means the same day or the next working day.
- (8) The reporting obligations under this Section are individual. Employers, supervisors, and administrators do not impede or inhibit the reporting obligations of any employee or other person.
- (b) **Reporting responsibilities.**
- (1) **Reportable incidents.** Reportable incidents are defined in subsection (a) of this Section.
- (2) **Minors and youth.** An OKDHS employee with knowledge of a reportable incident involving a minor or youth who is an OCA client, as defined in OAC 340:2-3-32(a)(2), is required to make an immediate referral to OCA intake. Any other person who has knowledge of this type of reportable incident involving an OCA client is required by law to make a prompt report to OCA intake, Child Welfare in an OKDHS local county office, or the statewide, toll free hotline (the "hotline"), 1-800-522-3511. Referrals to OCA intake are made in accordance with subsection (e) of this Section.
- (3) **Vulnerable adults.** An OKDHS employee who has knowledge of a reportable incident involving a vulnerable adult who is an OCA client, as defined in OAC 340:2-3-32(a), is required to make an immediate referral to OCA intake. Any other person who has knowledge of this type of reportable incident is required by law to make a report as soon as possible to OCA intake, the office of the district attorney in the county in which the alleged incident happened, or the local municipal police or sheriff's department.
- (4) **Immunity from liability.** Oklahoma law provides that any person exercising good faith and due care in making a report of alleged abuse, neglect, verbal abuse, or exploitation pursuant to the Oklahoma Child Abuse Reporting and Prevention Act or the Oklahoma Protective Services for Vulnerable Adults Act shall have immunity from any civil or criminal liability the person might otherwise incur.
- (5) **Questions about reporting.** A person who is uncertain if a particular incident is reportable contacts OCA intake, 1-800-522-8014, during business hours, and after hours call the Abuse Hotline, 1-800-522-3511.
- (c) **Failure to report.** Any person who knowingly and willfully fails to promptly report a reportable incident as provided for in this Section may be subject to administrative action or criminal sanctions. Section ~~10-104(C)~~ 10-104(E) of Title 43A and Section 7103(C) of Title 10 of the Oklahoma Statutes makes failure to report a misdemeanor, upon conviction. In addition, failure to report by an OKDHS employee may result in disciplinary action.
- (d) **False reporting.**
- (1) Any person who knowingly and willfully makes a false report regarding alleged maltreatment of a minor, or a report that the person knows lacks factual foundation, may be reported by OKDHS to local law enforcement for criminal investigation and, upon conviction, is guilty of a misdemeanor.
- (2) With regard to vulnerable adults, any person who willfully or recklessly makes a false report may be liable in a civil action for any actual damages suffered by the person(s) being reported and for any punitive damages set by the court or jury.
- (e) **Method of reporting.**
- (1) Any person obligated to report an allegation of suspected abuse, neglect, verbal abuse, or exploitation of an OCA client, or caretaker misconduct towards an OCA client, contacts OCA intake in Oklahoma City by telephone at 1-405-525-4850 or 1-800-522-8014, between 8:00 a.m. and 5:00 p.m. on normal business days. At all other times, the Statewide Abuse Hotline, 1-800-522-3511 accepts referrals on behalf of OCA. Referrals also are made by completing Form ~~OCA-1~~ 15GN001E, Office of Client Advocacy Intake Referral, and transmitting it by fax 1-405-525-4855, to OCA, Attn: OCA intake, or sending the same information in an e-mail addressed to *OCA.intake@okdhs.org.
- (2) Allegations of exploitation of residents of SORC, NORCE, and Greer are reported to the person designated by the facility administrator to receive and investigate reports of those allegations.
- (3) In lieu of contacting OCA intake, employees of SORC, NORCE, and Greer also have the option of contacting the quality assurance staff at those facilities. In this event, the reporting staff also notifies the OCA facility ombuds staff assigned to ~~the~~ the facility. OCA employees and facility staff who receive information about a reportable incident promptly contact OCA intake to transmit that information.
- (f) **Confidentiality of reporting party's identity.** OCA keeps confidential the identity of a person who reports an incident involving a vulnerable adult in accordance with Section 10-105(2) of Title 43A of the Oklahoma Statutes, and of a person who reports an incident involving a minor or youth in accordance with Section 7005-1.2(G)(7) of Title 10 of the Oklahoma Statutes. OCA accepts anonymous referrals.
- (g) **Retaliation prohibited.** Section 10-104(G) of Title 43A of the Oklahoma Statutes states that an employer shall not terminate the employment, prevent or impair the practice or occupation of or impose any other sanction on any employee solely for the reason that the employee made or caused to be made a report or cooperated with an investigation pursuant to the Vulnerable Adults Act, Section 10-101 et seq. of Title 43A of the Oklahoma Statutes.
- (h) **Staff training.** All administrators ensure their employees receive relevant training regarding their reporting responsibilities detailed in this Section. Except for employees of a Developmental Disabilities Services Division (DDSD) provider, employees receive this training within 30 calendar days of initial employment and subsequent training annually. The training for employees of DDSD providers is in accordance with OAC 340:100-3-38.

340:2-3-34. Administrator's responsibilities regarding allegations reportable to Office of Client Advocacy (OCA)

(a) **Immediate protection for safety, health, and welfare.** If OCA intake receives an allegation of caretaker maltreatment involving an OCA client from anyone other than the administrator, or the administrator's designee, of the facility or provider responsible for the client, OCA intake promptly notifies the applicable administrator of the allegation.

(1) Upon becoming aware of an allegation of caretaker maltreatment involving an OCA client, an administrator ensures the safety, protection, and needed medical attention of any client named in the allegation and other clients receiving services from the facility or provider.

(2) When criminal activity is alleged, other than caretaker abuse or neglect unless it involves a serious physical injury, the administrator immediately notifies the appropriate local law enforcement authority. The types of criminal activity which are reported to law enforcement include, but are not limited to, the use or possession of illegal drugs, domestic abuse, illegal sexual activity, illegal use of alcohol, theft of money, property, or medicine that is a controlled substance, and when someone other than a caretaker is believed to have committed the allegation.

(3) The administrator takes necessary personnel actions to ensure the protection and safety of the alleged victim(s) and other clients. OCA does not determine or approve personnel actions taken by an administrator in response to allegations reported to OCA.

(4) In the event of alleged abuse or neglect of a Hissom class member by a provider's employee or subcontractor, the administrator ensures the protection and medical attention for any class member named in an allegation or other individual served. In the event of alleged abuse or neglect by an individual serving as a provider, it is the responsibility of the class member's case manager to ensure protection, medical attention, or both for the class member. OCA intake notifies the applicable Developmental Disabilities Services Division (DDSD) area manager by e-mail within one working day of receipt of a referral of abuse or neglect by an individual serving as provider for the class member.

(b) **Preliminary assessment.** Upon learning of an incident reportable to OCA, the administrator:

(1) immediately ensures the safety of any client named in the referral and of other clients;

(2) secures any physical evidence and gathers documents within the possession of the facility or provider, custody, or control that may be relevant to the allegation;

(3) immediately takes photographs of any injuries. Photographs are taken by someone who was not involved in the incident that is the subject of the allegation relating to the injuries; and

(4) coordinates activities with OCA and any other agency or law enforcement authority involved in investigating the referral.

(c) **Collecting pertinent reports and documents.** The administrator determines which employees were present when

the alleged incident occurred and requires each employee to submit a written account of the alleged incident. The administrator collects medical records, other documents and reports which pertain to the alleged incident, written statements, and other documentary evidence within the possession of the facility or provider, custody, or control and places them in a holding file for investigative use by OCA and any other investigative authority. The administrator securely maintains any documents collected during the preliminary assessment.

(d) **OCA access to documents and evidence.** Upon request, an OCA investigator is provided a copy of and access to the original of written statements, incident reports, relevant documents and records, and other reports, photos, and other evidence collected during the preliminary assessment.

(e) **Prohibition from interviewing during preliminary assessment.** Employees of the facility or provider do not conduct an investigation of an alleged incident pending OCA's decision to accept the referral for investigation or during a pending OCA investigation. To avoid the consequences of over-interviewing parties involved in an alleged incident, the preliminary assessment is limited to inquiries about who was involved, obtaining written statements, and clarifying information needed to take appropriate action to ensure client safety. Determining if a staff member engaged in maltreatment is not the goal of a preliminary assessment and is avoided until the OCA disposition is determined. This prohibition does not extend to interviews and investigations conducted by law enforcement when responding to a report of criminal activity. OCA coordinates activities with local, state, and federal law enforcement entities to seek the most appropriate investigative response to the referral.

(f) **Facility and provider contact person.** Each administrator of a facility or provider responsible for the care of any of the individuals listed in OAC 340:2-3-32(a)(2) designates a contact person to receive the notice described in subsection (a) of this Section. The administrator informs the advocate general of the name, phone number, and e-mail address of the designated contact person, and immediately notifies the advocate general in writing, by mail or e-mail, of any changes in this information. The designated contact person is reasonably available by telephone, pager, or e-mail between 8:00 a.m. and 5:00 p.m. weekdays, except holidays. Form ~~OCA-INV-2~~ 15IV011E, Designation of Contact Person for Client Maltreatment Investigations, may be used for this purpose.

(g) **Documentation provided by SORC, NORCE, and Greer.** Within one business day of the Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Greer Center Facility (Greer) submitting to the Oklahoma State Department of Health (OSDH) an incident report, a five-day report or a final report regarding an allegation reported to OCA intake, the facility sends to OCA intake a copy by fax or e-mail attachment.

(h) **Ensuring confidentiality.** Administrators maintain information, files, and documents regarding referrals made to OCA intake, including OCA investigation reports distributed pursuant to OAC 340:2-3-36, in a manner that protects the confidentiality of information contained in them.

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340:2-3-35. Processing referrals received by the Office of Client Advocacy (OCA)

(a) **Disposition options.** OCA intake records on Form ~~OCA-1~~ 15GN001E, Office of Client Advocacy Intake Referral, or its electronic equivalent, the specifics of each referral received and makes an appropriate disposition regarding how the referral is to be handled. Consideration is given to all known information to determine an appropriate disposition and course of action. The disposition options and criteria include, but are not limited to, the options described in (1) through (7) of this subsection.

(1) **OCA investigation.** This disposition means OCA opens an investigation of an allegation of caretaker maltreatment.

(2) **Assign for caretaker conduct review.** This disposition means the facility named in the referral is given responsibility to conduct an internal caretaker conduct review in accordance with OAC 340:2-3-37. Within one working day of receiving a referral given this disposition, OCA intake notifies the administrator or designated contact person. OCA intake documents the notification on Form ~~OCA-1~~ 15GN001E, or its electronic equivalent. This disposition does not apply to allegations involving Developmental Disabilities Services Division (DDSD) clients other than residents of Southern Oklahoma Resource Center (SORC), Northern Oklahoma Resource Center of Enid (NORCE), and the Greer Center Facility (Greer).

(3) **Refer to advocate.** This disposition is made when the referral involves a Hissom class member or a resident of SORC, NORCE or Greer, and involves a concern which, based on the information provided, does not rise to the level of abuse, neglect, verbal abuse, caretaker misconduct, or exploitation. Within one working day of receipt of the reported incident, the applicable OCA advocate and his or her supervisor are notified of the matter by e-mail or telephone for appropriate follow-up inquiry. If the advocate knows or learns of facts which indicate a more appropriate disposition, the advocate immediately notifies OCA intake.

(4) **Refer to another administrative entity for handling.** This disposition means OCA intake forwards the information to another state agency or OKDHS division or office for handling. This disposition is appropriate when information provided by the reporting party does not include an allegation of caretaker maltreatment within the purview of OCA, but rather involves complaints about employee performance or allegations within the scope of another administrative entity. When this disposition is made, OCA intake makes the referral within one working day of receipt of the reported incident. These referrals are not assigned to OCA investigators for handling or intervention.

(5) **Refer to law enforcement.** This disposition is used when the referral involves possible criminal activity and it is not within OCA's investigative authority as described in OAC 340:2-3-32(a). This disposition is not used when OCA opens an investigation on a referral even

though a law enforcement agency also is investigating the matter.

(6) **Refer for grievance.** When a referral to a grievance system is made, OCA intake notes the specifics of that referral on Form ~~OCA-1~~ 15GN001E, or its electronic equivalent. The referral is directed to the appropriate entity for handling as a grievance when the content of the referral is not caretaker maltreatment, but a complaint or concern that can be addressed by a grievance. If the complaint can be addressed as a grievance and is referred for grievance by OCA, the entity promptly notifies its local grievance coordinator. Indicators that a referral is appropriate for handling as a grievance include complaints about:

(A) conditions which do not endanger residents;

(B) staff improprieties which do not constitute abuse, neglect, verbal abuse, caretaker misconduct, or exploitation; and

(C) privileges and restrictions not involving the use of isolation, force, or restraints.

(7) **No action required.** This disposition is made when OCA takes no action in response to the referral because the information provided is for notification purposes only and does not include an allegation, complaint, or concern appropriate for another disposition. This disposition is also made when an OCA investigation is not warranted in an Adult Protective Services substantiated case.

(8) **Refer to administration.** This disposition means the matter is not within the purview of OCA, another OKDHS unit, or another state agency but is relevant to the operations of a facility or provider. When this disposition is used, OCA intake contacts the administrator of the facility or provider to inform the administrator of relevant information relating to the referral.

(9) **Refer to DDSD Quality Assurance (QA).** This disposition is made when an allegation involves an alleged contract violation that does not involve caretaker maltreatment.

(b) **Notifying law enforcement.** If a referral opened as an OCA investigation involves possible criminal activity on the part of a caretaker, OCA intake determines from the reporting party or the designated contact person for the facility or provider whether law enforcement was notified. If law enforcement has already been notified, OCA intake documents that information on Form ~~OCA-1~~ 15GN001E, or its electronic equivalent. If law enforcement has not been called or it is unclear if the matter has been reported to law enforcement, OCA intake requests the contact person at the facility or provider to notify law enforcement immediately. If acceptable assurances are not given that law enforcement has been or will be notified by the end of the business day, OCA intake notifies the appropriate law enforcement authority and notes the specifics on Form ~~OCA-1~~ 15GN001E, or its electronic equivalent.

(c) **Assignment process for referrals opened for investigation.** A referral accepted for investigation is assigned to a specific OCA investigator. Investigations involving Hissom class members are assigned within one working day of making a disposition to investigate the allegation. When urgent

circumstances exist in a case opened for investigation, an assignment is made and the investigation commenced immediately.

340:2-3-36. Investigation procedures

(a) **Initiation of Office of Client Advocacy (OCA) investigation.** The assigned OCA investigator conducts a prompt investigation of the referral. The investigator contacts the applicable administrator or designee to arrange for document production, site visits, and interviews.

(1) The administrator for the facility or provider who employed an accused caretaker at the time of the alleged incident informs that employee of:

(A) the name and telephone number of the OCA investigator;

(B) the investigative process described in this Section;

(C) except as stated in paragraph (2) of this subsection, the employee's rights and responsibilities relating to the investigation described in subsection (d) of this Section, using Form ~~OCA-4~~ 15IV005E, Rights and Responsibilities of Accused OKDHS Employees, Form ~~OCA-4-A~~ 15IV006E, Rights and Responsibilities of Accused Caretakers, or a substantially similar provider or agency form, a copy of which is provided to the OCA investigator except as stated in paragraph (2) of this subsection; and

(D) the allegation made against the accused caretaker without divulging the identity of the reporting party or the substance of the evidence.

(2) In cases involving caretakers subject to the Community Services Worker (CSW) Registry, the rights and responsibilities of accused community services workers are found in OAC 340:100-3-39. The administrator or designee promptly completes Form ~~DDS-59~~ 06PE059E, Rights and Responsibilities of Accused Community Services Worker in an Investigation of Abuse, Neglect, or Exploitation, in accordance with OAC 340:100-3-39(d)(2)(C). The administrator or designee mails Form ~~DDS-59~~ 06PE059E to the worker when it is not possible to personally give it to a worker who is no longer employed by the provider.

(3) On request and for good cause shown, OCA expedites the time frames contained in this subsection for conducting an investigation.

(b) **Access.** The applicable administrator arranges for the OCA investigator to have immediate and direct access to any alleged victim in the referral who is still a client of the facility or provider. During an OCA investigation, Oklahoma Department of Human Services (OKDHS), Office of Juvenile Affairs (OJA), Department of Rehabilitation Services (DRS), Department of Mental Health and Substance Abuse Services (DMHSAS), the J.D. McCarty Center, providers, and facilities, and persons who contract with them, provide OCA access to all employees, clients, facilities, locations, files, and records of any nature that may pertain to the investigation. Denial of access may be grounds for termination of a contract between OKDHS and a contractor.

(c) **Interference prohibition.**

(1) Section 7103 of Title 10 of the Oklahoma Statutes prohibits discrimination or retaliation against a person who in good faith provides information about a reportable incident or testifies in a proceeding.

(2) Section 455 of Title 21 of the Oklahoma Statutes makes it a felony to interfere with a child abuse investigation or a vulnerable adult investigation under Title 43A. An OKDHS employee who interferes with an OCA investigation also may be subject to administrative action. Interference includes but is not limited to:

(A) intimidating, harassing, or threatening a party to the investigation;

(B) retaliation against an employee for reporting an allegation; or

(C) denial of access to clients, employees, facilities, witnesses, records, or evidence.

(3) Section 10-104(G) of Title 43A of the Oklahoma Statutes states that an employer shall not terminate the employment, prevent or impair the practice or occupation of or impose any other sanction on any employee solely for the reason that the employee made or caused to be made a report or cooperated with an investigation pursuant to the Vulnerable Adults Act, Section 10-101 et seq. of Title 43A of the Oklahoma Statutes.

(d) **Rights and responsibilities of accused caretakers.**

The rights and responsibilities of an accused caretaker during an OCA investigation are outlined in this subsection. The rights and responsibilities of a community services worker are found at OAC 340:100-3-39.

(1) **Rights.** During the investigation process, an accused caretaker has the right to:

(A) be advised by the administrator of the nature of the allegation(s) made against him or her in the referral;

(B) be advised by OCA of the investigative process involving caretaker maltreatment;

(C) be interviewed by the investigator and allowed to give his or her position regarding the referral;

(D) be advised by the investigator of the substance of the evidence against him or her, but not the identity of the person reporting the allegation;

(E) submit or supplement a written statement relating to the allegations;

(F) seek advice from other parties concerning a caretaker's rights and responsibilities in OCA investigations;

(G) decline to answer any question when he or she reasonably believes the answer to the question may incriminate him or her in a criminal prosecution; and

(H) be notified in writing by his or her employer of the outcome of the investigation.

(2) **Responsibilities.** During the investigative process, an accused caretaker has the responsibility to:

(A) prepare written statements and reports relevant to the investigation upon request;

(B) be available for interviews and accommodate the investigator in scheduling of interviews;

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- (C) refrain from any action that interferes with the investigation, including any action that intimidates, threatens, or harasses any person who has or may provide information relating to the allegation; and
- (D) provide pertinent information and respond fully and truthfully to questions asked.
- (e) **Educational employees.** This subsection applies to an employee of a school district providing contract educational services on-site at a facility, as defined in OAC 340:2-3-2, who is either a witness or an accused caretaker in an investigation opened by OCA.
- (1) The administrator of the facility where the incident took place notifies the principal of the school of the nature of the allegation and the name of the assigned OCA investigator.
- (2) The principal of the school is responsible for notifying the school employee of the reason for the investigative interview, advising the employee of his or her rights and responsibilities relating to the OCA investigation, and arranging for the employee's appearance at an investigative interview. This requirement is for purposes of notification and coordination of the investigative process and does not extend to ensuring the protection of the alleged victim(s) or other clients at the facility where the educational services are provided. The administrator of the facility where the alleged incident took place is responsible for protection of clients.
- (3) OCA investigates educational employees who meet the definition of a caretaker in OAC 340:2-3-2.
- (f) **Contractor's employees.** This subsection applies to an employee of a contractor of a provider or facility when the employee is an accused caretaker in an investigation opened by OCA.
- (1) The administrator of the provider agency or facility where the incident took place notifies the chief administrative officer of the contractor of the nature of the allegation against the contractor's employee and the name of the assigned OCA investigator.
- (2) The chief administrative officer of the contractor is responsible for notifying the contract employee of the reason for the investigative interview, advising the employee of his or her rights and responsibilities relating to the OCA investigation, and arranging for the employee's appearance at an investigative interview. This requirement is for purposes of notification and coordination of the investigative process. The administrator of the provider agency or facility where the alleged incident took place is responsible for protection of clients.
- (g) **Document collection and review.**
- (1) The investigator gathers and reviews relevant documents including, but not limited to:
- (A) incident reports and other written reports, accounts, and statements prepared during the preliminary assessment;
- (B) medical records;
- (C) photos; and
- (D) facility or provider logs, activity and tracking documents.
- (2) If the OCA investigator is denied access to records, documentation, or other information relevant to an investigation involving a vulnerable adult, OKDHS Adult Protective Services is contacted for assistance in petitioning the court for an order allowing access.
- (h) **Investigative interviews.** The investigator interviews or attempts to interview persons known or identified to have information about the referral. If an injury is alleged, the investigator or other appropriate person observes, notes, and documents apparent injuries, and obtains pertinent medical documentation, including photographic evidence. Interviews are conducted in private. No person other than the investigator and the person being interviewed is allowed to attend an interview except a person necessary to facilitate communication. An attorney or other representative of the person being interviewed attends an interview only as a silent observer with prior permission of the advocate general or designee.
- (i) **Interview protocols.** The OCA investigator conducts a separate private interview with each alleged victim, available witnesses to the alleged maltreatment, and persons who allegedly were directly or indirectly involved in the allegation, persons with knowledge of relevant information, and each caretaker accused of the maltreatment. When possible, all other witnesses are interviewed prior to interviewing the accused caretaker(s).
- (1) **Tape recording of interviews.** OCA investigators tape record every interview. To maintain confidentiality of the information provided in an interview, no tape recording by the person being interviewed or by anyone else in attendance is permitted. Tape recordings of interviews remain with the OCA investigative file. OCA files and tape recordings are not public documents.
- (2) **Explanation of the process.** The investigator informs persons interviewed of the investigative process.
- (3) **Presentation of the allegation.** The OCA investigator verbally informs each accused caretaker of the substance of the allegation(s). In general, the investigator discloses only the nature of information learned during the investigation and does not identify the persons who provided information. The identity of the reporter of the allegation is never disclosed during the investigation. If during the course of an investigation a witness is identified as a potential accused caretaker, the investigator interviews the witness again to inform the witness that he or she is a potential accused caretaker. At that time, the witness is informed of the substance of the evidence and relevant information learned during the investigation and provided an opportunity to respond.
- (4) **Opportunity for accused caretakers to respond.** During the interview with an accused caretaker, the OCA investigator provides the caretaker an opportunity to respond to the allegation(s) and to supplement any information previously provided in written statements. Following the initial interview of the accused caretaker, if the investigator obtains information to which the accused caretaker did not have an opportunity to respond, the investigator conducts another interview with the caretaker.

The investigator advises the accused caretaker of the substance of the new information and provides an opportunity to present a response.

(5) **Interpreter services for persons who are deaf or hard of hearing.** When the investigator needs to interview a person who is deaf or hard of hearing, the facility or provider agency who employed the person at the time of the alleged incident provides, at no cost to OCA, oral or sign language interpreter services by an independent and qualified interpreter. Interpreter services for OKDHS employees and clients are provided in accordance with OAC 340:1-11-10.

(6) **Scheduling interviews.** To schedule an interview with an accused caretaker, the investigator contacts by phone or regular mail the administrator of the facility or provider that employs the caretaker. If a reasonable time has passed without being able to schedule an interview, the investigator contacts the administrator of the facility or provider to request the administrator to compel the employee to participate. If unsuccessful, the investigator sends both a certified letter and a letter by regular mail to the caretaker's last known address notifying the caretaker of the investigation and offering an opportunity to be interviewed, setting a date and time for a response. The letter informs the caretaker that the consequence of failure to participate is for the OCA investigative report to be completed without the caretaker's statement and a finding is made based on available information. For other persons needing to be interviewed, the investigator follows the same sequence as for an accused caretaker, but the certified letter only requests their participation in an interview.

(7) **Failure to appear.** If a person fails to appear for a scheduled interview without good cause, as determined by the advocate general, the investigator completes the investigative report without interviewing that person. The investigative report includes an explanation of why the interview was not conducted, including documentation of efforts to interview the person.

(j) **Exit notice.** Within 30 calendar days of assignment of a referral to be investigated, the assigned OCA investigator contacts by e-mail the applicable administrator or designee, or OKDHS long-term care nurse, whichever is applicable, when the information gathering portion of the investigative process is completed. The investigator informs the administrator of any areas of concern identified and that a written report will be prepared with the final finding. Preliminary findings are not required.

(k) **The written investigative report.** After completing the information gathering portion of the investigative process the investigator prepares a written investigative report containing:

- (1) the allegation(s) contained in the referral investigated including the date, time, and location of the alleged incident(s), the date the allegation was reported to OCA, and the assigned OCA case number;
- (2) a statement of any physical injuries sustained by the alleged victim(s);
- (3) information regarding any involved law enforcement entities;

- (4) a recommendation for the district attorney whether to consider further investigation;
- (5) the applicable definition(s) of the type of maltreatment at issue, such as abuse, neglect, verbal abuse, exploitation, or caretaker misconduct;
- (6) the finding(s) in accordance with subsection (l) of this Section;
- (7) a list of the involved parties, their titles and role in the matter, if they were interviewed and, if so, when, and whether interviewed face-to-face or by telephone;
- (8) the name, address, and telephone numbers of any interpreter used during the investigation;
- (9) an explanation of the basis for the finding(s);
- (10) a summary of relevant information obtained during each interview conducted during the investigation;
- (11) any areas of concern relating to the referral identified during the investigation regarding facility, provider, or OKDHS practices or procedures which have implications for the safety, health, or welfare of clients but which do not rise to the level of abuse or neglect;
- (12) a list of relevant documents and records reviewed during the investigation;
- (13) a list of attachments to the report that are provided upon request; and
- (14) an explanation for any delays in meeting the time frames for completing the investigation report contained in this Section.

(l) **Investigative findings.** The OCA investigator determines the appropriate finding for each allegation contained in the referral investigated. Findings are made based on a greater weight of the evidence standard. The finding options are:

- (1) **"confirmed"** means that the greater weight of the available evidence establishes that the alleged maltreatment occurred;
- (2) **"not confirmed"** means the greater weight of the available evidence indicates that the alleged maltreatment did not occur; or
- (3) **"ruled out"** means no evidence was discovered that indicates the alleged maltreatment occurred.
- (4) **"defer"** means OCA will defer the completion of an investigation and the issuance of a finding upon reasonable request to do so by a law enforcement agency having investigative authority.

(m) **Identification of the responsible caretaker.** When a confirmed finding is made, the investigator determines the caretaker(s) responsible for the maltreatment. The administration can be named as responsible when the policies, procedures, or practices adopted by the administration of a facility, provider, or day treatment program are the primary factor resulting in the maltreatment of individual clients.

(n) **Dissemination of the OCA investigative reports involving caretakers not subject to the Community Services Worker Registry.** Within 60 calendar days from the assignment of a referral to be investigated, the OCA written investigative report is completed.

- (1) Except as provided in subsection (o) of this Section, a copy of the final OCA investigation report is sent to the administrator of an affected facility or provider agency.

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The administrator is responsible for notifying the client or the client's legal representative of the OCA finding.

(2) If the referral alleged abuse, verbal abuse, neglect, or exploitation, a copy also is sent to the applicable district attorney.

(3) A copy also is sent to the appropriate OKDHS state office administrator, executive director of OJA, the director of DRS, the director of DMHSAS, or the director of the J.D. McCarty Center, whichever is applicable.

(4) When an administrator is named as an accused caretaker in the allegation, OCA forwards the investigative report to the chair of the board of directors of the facility or provider agency, or to the director of the state agency operating the facility, whichever is applicable.

(5) A copy of OCA's report is sent to the Oklahoma State Department of Health (OSDH) if the investigation involved a day treatment program.

(6) The administrator of an OKDHS operated facility provides accused OKDHS employees who work at the facility a letter which summarizes the allegation and states the OCA finding. If an accused caretaker is an OKDHS employee, the applicable OKDHS division director or designee is responsible for providing the employee with a letter which summarizes the allegation and states the OCA finding.

(7) If client maltreatment by a licensed nurse is confirmed, a copy of OCA's report is submitted to the Oklahoma State Board of Nursing.

(8) When appropriate in cases involving a vulnerable adult, a copy of OCA's report is sent to any state agency with concurrent jurisdiction over persons or issues identified in the investigation, including but not limited to OSDH and any appropriate state licensure or certification board, agency, or registry. This includes sending OSDH a copy of any report in which at least one of the accused caretakers is a certified nurse aide (CNA).

(9) OCA distributes its investigation reports by United States mail, fax, or e-mail, whichever is appropriate.

(o) Dissemination of reports involving Hissom class members and caretakers subject to the Community Services Worker (CSW) Registry.

(1) All OCA investigations involving a confirmed finding against a community services worker, or a Medicaid personal care assistant employed by a Medicaid Personal Care Services Provider are processed in accordance with OAC 340:100-3-39 and OAC 317:35-15.

(2) After the OCA investigation report has been approved, an e-mail notice of the areas of concern in the report is sent to the administrator, the applicable DDS area manager, and the OKDHS long-term care nurse, whichever are applicable.

(3) When the OCA finding does not confirm an allegation, OCA sends a copy of the report pursuant to Section 10-110(B) of Title 43A of the Oklahoma Statutes, to the administrator, the DDS director or the APS programs manager, whichever is applicable, the assigned OKDHS long-term care nurse when applicable, and the applicable district attorney.

(4) When the OCA finding confirms an allegation against an accused caretaker who is not a community services worker, OCA sends a copy of the report to the administrator, the DDS director, and the applicable district attorney.

(5) When the OCA finding confirms an allegation against a caretaker who is a community services worker or a Medicaid personal care assistant, OCA submits a copy of the report to the DDS director or the APS programs manager, whichever is applicable, and the applicable district attorney and processes the report in accordance with OAC 340:100-3-39. When the due process procedures relating to the CSW Registry have been completed, OCA sends a copy of the report to the applicable administrator and the assigned OKDHS long-term care nurse if applicable.

(6) The Hissom class member's assigned OCA advocate notifies the class member and the class member's guardian or close family member of the result of the investigation when the investigative finding has become final.

(7) If maltreatment by a guardian is confirmed, a copy of OCA's investigation report is submitted to the applicable guardianship court.

(p) Confidentiality of OCA investigative reports. Persons receiving copies of OCA investigative reports are bound by the confidentiality provisions of Sections 7005-1.2 through 7005-1.4 and 7107 et seq. of Title 10, and Section 10-110 of Title 43A of the Oklahoma Statutes, whichever is applicable.

(q) Confirmed findings involving OKDHS operated facilities. The findings of an OCA investigation report involving client maltreatment at an OKDHS operated facility are considered final when the time for requesting review pursuant to OAC 340:2-3-62(b) has expired and review has not been requested, or that review was timely requested and has concluded.

(1) When the Children and Family Services Division (CFSD), the Field Operations Division, or DDS receives a copy of a final OCA investigative report or notice that a review pursuant to OAC 340:2-3-62 has been concluded, within 60 working days, the applicable division director notifies the advocate general in writing of:

(A) any personnel action taken or to be taken with regard to each accused caretaker named in the report;

(B) any corrective action taken or to be taken regarding areas of concern noted in the report; and

(C) for each worker found to have engaged in maltreatment, whether there have been any prior confirmations by OCA or the facility for client maltreatment by the worker and, if so, the basis for each such finding, and the personnel action taken in response.

(2) If personnel action has or will be taken, the division director also notifies the OKDHS Human Resources Management Division director. If the final OCA finding does not confirm maltreatment, no information or material pertaining to the allegation or the investigation is placed in the personnel file of an accused caretaker.

(3) OCA reports information regarding confirmed findings to the Oklahoma Commission for Human Services (Commission) during executive session.

(r) **Findings involving a Hissom class member.** This subsection applies to the administrator of a provider that employed, or contracted with a contractor that employed, an accused caretaker named in an OCA investigation report.

(1) Within 60 calendar days of receipt of a final OCA investigation report, the DDS/D director or designee notifies the advocate general in writing:

- (A) if any personnel action has or will be taken with regard to each accused caretaker named in the report; and
- (B) of any corrective action taken or to be taken regarding areas of concern noted in the report.

(2) OCA reports information regarding confirmed findings to the Commission during executive session.

(s) **Storage and retention of OCA investigative records.** OCA maintains the original report, supporting documents, and applicable recorded tapes in locked file cabinets in accordance with the applicable OKDHS records management and disposition plan. Access to investigative files and records is limited to OCA employees on a need to know basis. Requests by OKDHS employees for access to or copies of OCA investigative reports are made to the advocate general on a need to know basis.

340:2-3-37. Caretaker conduct review (CCR)

(a) **Application.** This Section applies to referrals received by the Office of Client Advocacy (OCA) which OCA refers to a facility for an internal CCR in accordance with OAC 340:2-3-35(a)(2). This Section does not apply to allegations involving maltreatment of a Hissom class member or person receiving Developmental Disabilities Services Division (DDS/D) waiver services.

(b) **Assignment to a facility to conduct a CCR.**

(1) When OCA receives a referral that indicates possible caretaker misconduct, in lieu of an investigation OCA intake may refer it to the facility where it allegedly occurred for handling as a CCR if:

- (A) there is no injury or evidence that the client might have been exposed to a significant risk of harm;
- (B) there is a minor physical injury and it is not a suspicious injury;
- (C) there is a serious physical injury and the known credible information makes it unlikely that the serious injury was the result of abuse or neglect; or
- (D) excessive or unauthorized use of force is alleged and there is no injury or only a minor injury that is not suspicious.

(2) In addition to the referrals in subsection (b)(1), at Oklahoma Department of Human Services (OKDHS) operated facilities, a referral indicating possible maltreatment may be referred to the facility for handling as a CCR if the allegation involves a serious physical injury that occurred under unexplained or unusual circumstances.

(c) **Protocol for conducting a CCR.** When OCA intake assigns a facility the responsibility to conduct a CCR, the administrator or designee takes necessary steps to ensure the safety of all clients and to protect the integrity of all evidence. A facility employee designated to conduct a CCR follows

the investigative procedures described in OAC 340:2-3-36, with the exception of tape recording the interviews in OAC 340:2-3-36(i)(1), including:

- (1) reviewing pertinent documentation, records, and evidence collected;
- (2) viewing any injuries and photos of injuries, and obtaining photos of injuries;
- (3) obtaining written statements and conducting interviews with:
 - (A) each alleged victim;
 - (B) each eyewitness;
 - (C) other persons with knowledge relevant to the allegation; and
 - (D) each accused caretaker;
- (4) reviewing statutes, policies, directives, standards, rules, or practices relevant to the allegation;
- (5) analyzing the accused caretaker's actions in relation to relevant statutes, policies, directives, standards, rules and practices; and
- (6) determining the appropriate finding(s) in accordance with OAC 340:2-3-36(l).

(d) **Returning the investigation responsibility to OCA.**

If at any time during the CCR information is learned that gives cause to believe that a client was the victim of caretaker misconduct resulting in a serious injury, abuse or neglect, the administrator immediately discontinues the CCR and contacts OCA intake to report the new information warranting an OCA investigation. OCA intake notes the new information and changes the disposition on Form ~~OCA-1~~ 15GN001E, Office of Client Advocacy Intake Referral, or its electronic equivalent, and the case is assigned to an OCA investigator for investigation in accordance with OAC 340:2-3-35(c).

(e) **Written report of CCR.** After completion of the CCR process and determination of the appropriate finding, the person conducting CCR prepares a written report. Facilities are encouraged, but not required, to use the OCA format for CCR reports, Form ~~OCA-7~~ 15IV007E, Caretaker Conduct Review Report. The written report contains:

- (1) the allegation(s), including the dates, times, and location of the alleged incident(s), the date the allegation was reported to OCA, and the OCA case number;
- (2) a statement of any injury sustained by the alleged victim(s) and, in cases involving an injury, a statement whether photographs were taken of the injury and if so, the date they were taken;
- (3) the finding(s), whether caretaker misconduct did or did not occur, in accordance with OAC 340:2-3-36(m);
- (4) a list of the involved parties, their titles and role in the matter, whether they were interviewed and, if so, when;
- (5) citation to pertinent statutes, policies, directives, standards, rules, and practices, when applicable;
- (6) an explanation of the basis for the finding(s);
- (7) a summary of pertinent information obtained in interviews conducted during the review;
- (8) a list of relevant documents and records reviewed;
- (9) a list of attachments to the report;

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(10) a list of areas of concern identified during the course of the investigation regarding facility or OKDHS practices or procedures which have implications for the safety, health, or welfare of clients but which do not rise to the level of abuse or neglect; and

(11) either on a cover memo or at the end of the report, the signature and date signed by the person who conducted the CCR, and the signature of the person who reviewed and approved the report.

(f) **Time for completion of report.** The final written report is submitted to the advocate general within 30 calendar days from the date that OCA intake notified the administrator that an allegation is referred for CCR.

(g) **OCA processing of CCR reports.** The administrator transmits the completed CCR to the advocate general. The advocate general or designee reviews the CCR report for completeness and appropriateness of the finding. If a report is incomplete or the finding is questionable, OCA contacts the administrator to request further inquiry into the allegation. OCA opens an investigation if a report indicates the need.

(h) **Review by Developmental Disabilities Services Division (DDSD) director.** Within five working days of completion of a CCR report at the Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Greer Center Facility (Greer), the facility administrator or designee informs the client and the client's guardian or parent of the result of the CCR. If the client or the guardian or parent does not concur with the finding(s), the facility administrator or designee notifies the advocate general in writing by e-mail or letter. The advocate general refers the matter to OCA's grievance coordinator to process for review by the DDSD director as a contested grievance in accordance with OAC 340:2-3-46 and 340:2-3-51(g) and the client or guardian or parent who did not concur with the finding(s) is considered the grievant for purposes of that review. If the grievant does not concur with the proposed resolution of the division director or designee, the matter is reviewed by the Grievance and Abuse Review Committee (GARC) in accordance with OAC 340:2-3-62 and 340:2-3-64.

(i) **State office administrator's report.** The findings in a CCR are considered final when the time for requesting review pursuant to the paragraph (h) of this Section has expired and review has not been requested, or that review was timely requested and has concluded.

(1) Within 60 calendar days of the finding becoming final, the state office administrator or designee informs the advocate general in writing of:

- (A) any personnel action taken or to be taken;
- (B) any corrective action taken or to be taken; and
- (C) for each worker found to have engaged in care-taker misconduct, whether there has been any prior confirmation by OCA or the facility for client maltreatment by the worker and, if so, the basis for each finding and the personnel action taken in response.

(2) If personnel action is involved, the state office administrator also notifies the OKDHS Human Resources Management Division director.

(3) If a CCR has not resulted in a confirmed finding, no information or material pertaining to the allegation or the investigation is placed in the personnel files of any employee named in the report.

340:2-3-38. Investigation of foster parent complaints of retaliation and discrimination

(a) **Application.** This Section describes processes relating to allegations of retaliation and discrimination against a foster parent by an employee of the Oklahoma Department of Human Services (OKDHS) or a child placing agency. The Office of Client Advocacy (OCA) is designated by Sections 7004-3.4(D) and 7204.1 of Title 10 of the Oklahoma Statutes to conduct administrative investigations into these allegations.

(b) **Definitions.** The following words and terms when used in this Section shall have the following meanings unless the context clearly indicates otherwise:

(1) **"Administrator,"** with regard to a child placing agency, means the chief administrative officer of the agency.

(2) **"Child placing agency"** means a private agency licensed to place children in foster family homes, group homes, adoptive homes, transitional or independent living programs, or family child care homes or other out-of-home placements, and which approves and monitors such placements and facilities in accordance with the licensing requirements established by the Oklahoma Child Care Facilities Licensing Act. [10 O.S. § 401 through 415]

(3) **"Child Welfare division"** means the OKDHS Field Operations Division (FOD) and the Children and Family Services Division (CFSD).

(4) **"DDSD"** means the OKDHS Developmental Disabilities Services Division (DDSD).

(5) **"Discrimination"** means knowing and willful application of a different standard to a particular foster parent which negatively affects the foster parent.

(6) **"Harassment"** means a knowing and willful course of conduct, statements, or behaviors serving no legitimate purpose directed at a foster parent that a reasonable person in the same or similar circumstances would find intimidating or substantially distressing.

(7) **"Retaliation"** means threatening a foster parent with removal of a child in the foster parent's care, harassing a foster parent, refusing or failing to place a child in a licensed or certified foster home, or disrupting a child placement in reprisal for the foster parent engaging in protected activity listed in (c)(2) of this Section.

(8) **"State office administrator"** means the FOD director, CFSD director, DDSD director, ~~or both~~, or their designees.

(c) **Scope.** A foster parent has the right, without fear of reprisal or discrimination, to lodge concerns and complaints with respect to the providing of foster care services. OCA initiates investigations of allegations that:

(1) an employee of OKDHS or a child placing agency has:

- (A) threatened a foster parent with removal of a child in the foster parent's care;

- (B) harassed a foster parent;
- (C) refused or failed to place a child in a licensed or approved foster home; or
- (D) disrupted a child placement; and
- (2) for the purpose of retaliation or discrimination against a foster parent who has:
 - (A) filed or attempted to file a grievance with OKDHS (see OAC 340:2-3-45) or with a child placing agency, whichever is applicable;
 - (B) provided information regarding foster care services to any state official or OKDHS employee; or
 - (C) testified, assisted, or otherwise participated in an investigation, proceeding, or hearing against OKDHS or a child placing agency.
- (d) **Exclusions.** The provisions of this Section do not apply to:
 - (1) a complaint by a foster parent regarding the result of a criminal, administrative, or civil proceeding for a violation by that foster parent of a law, rule, or contract provision, or an action taken by OKDHS or a child placing agency in conformity with the result of any such proceeding;
 - (2) allegations of acts of retaliation or discrimination that occurred more than one year prior to the date of the foster parent complaint; or
 - (3) allegations of a pattern of retaliation or discrimination the last incident of which occurred more than one year after the foster parent participated in protected activity.
- (e) **What is reportable.** Section 7204.1 of Title 10 of the Oklahoma Statutes provides that any foster parent who has reasonable cause to believe he or she has been improperly treated by an employee of OKDHS or a child placing agency, as outlined in subsection (c) of this Section, may file a complaint with OCA. The law provides that persons making a report in good faith under this Section may not be adversely affected solely on the basis of having made such report. The law also provides that any person who knowingly and willfully makes a false or frivolous report or complaint or a report that the person knows lacks factual foundation may be subject to loss of foster parent approval or licensure status.
- (f) **Reporting procedure.** Foster parents may file complaints by contacting:
 - (1) the Foster Parent Hotline, 1-800-376-9729; or
 - (2) OCA's offices in Oklahoma City, 1-405-525-4850 or 1-800-522-8014.
- (g) **Confidentiality.** At the request of the reporter, OCA maintains confidential the identity of the reporter until the advocate general reports the results of the investigation to the Commission for Human Services (Commission) in accordance with subsection (m) of this Section. OCA maintains written records regarding the reporting source to provide information to the extent known at the time the report is received, including:
 - (1) the names and addresses of the foster child and the person(s) responsible for the child's welfare;
 - (2) the nature of the complaint; and
 - (3) the names of the persons and agencies responsible for the allegations contained in the complaint.
- (h) **Interference prohibition.**
 - (1) An OKDHS employee who interferes with an OCA investigation may be subject to administrative action for misconduct under OKDHS personnel policy relating to cause for disciplinary action if the employee attempts to intimidate a witness, foster parent, or other OKDHS employee, or threatens any of them with physical or mental harm.
 - (2) Interference includes, but is not limited to:
 - (A) intimidating, harassing, or threatening a party to the investigation;
 - (B) retaliation against an employee for cooperating during an OCA investigation;
 - (C) denial of access to clients, employees, facilities, witnesses, records, or evidence; and
 - (D) causing or influencing another person to provide false information during the investigation.
 - (i) **Initiation of OCA investigation.** Upon acceptance of a report of retaliation or discrimination against a foster parent, OCA assigns an investigator to investigate the allegations in accordance with this Section. OCA's investigation does not duplicate and is separate from any investigation mandated by the Oklahoma Child Abuse Reporting and Prevention Act or other investigations having formal notice or hearing requirements.
 - (j) **Rights and responsibilities of employees.** The rights and responsibilities of OKDHS employees in an OCA foster parent investigation are listed in (1) through (7) of this subsection.
 - (1) Employees make themselves available for interviews and accommodate the investigator in scheduling interviews.
 - (2) Employees provide pertinent information and respond fully and truthfully to questions asked.
 - (3) In addition to being interviewed, employees may submit written statements relating to the events in question.
 - (4) Employees may seek advice concerning their rights and responsibilities from other parties within or outside OKDHS.
 - (5) Employees prepare written statements or reports relevant to the investigation upon request.
 - (6) Employees, who reasonably believe answers to official inquiries regarding the events in question may incriminate them in a criminal prosecution, may decline to answer those questions.
 - (7) Employees interviewed do not discuss their interviews with anyone outside of OCA.
 - (k) **Access.** OCA at all times is granted access to any foster home which is approved, authorized, or funded by OKDHS or a child placing agency.
 - (1) **Investigation procedures.** Investigations are conducted in accordance with OAC 340:2-3-36 unless otherwise provided in this Subchapter.
 - (1) **Notifying administrators and accused caretakers.** The assigned investigator notifies the applicable administrator or state office administrator of the investigation and arranges for document production, site visits, and interviews. The administrator or state office administrator

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who employed any accused employee at the time of an alleged incident promptly informs the accused employee of:

- (A) the name and telephone number of the OCA investigator;
 - (B) the investigative process;
 - (C) the employee's rights and responsibilities relating to the investigation described in subsection (j) of this Section, using Form ~~OCA 4-B~~ 15IV006E, Investigations of Foster Parent Retaliation Complaints - Rights and Responsibilities of Accused OKDHS Employees, a copy of which is provided to the OCA investigator; and
 - (D) the nature of the allegation(s) made against the employee; however, at this time the employee is not provided the details of the allegations or the substance of the evidence.
- (2) **OCA access to evidence.** Applicable administrators and state office administrators facilitate and cooperate with the OCA investigation by:
- (A) providing access to requested information;
 - (B) producing relevant documents, files, and records, accompanying the investigator on foster home visits when requested by OCA; and
 - (C) providing access to accused employees and others who have knowledge of relevant information.
- (3) **Document review and interviews.** The OCA investigator conducts a prompt investigation in accordance with OAC 340:2-3-36(g) through (i) unless otherwise provided in this Section.
- (4) **Exit notice.** The OCA investigator provides an exit notice, either electronically or by telephone, to the applicable administrator or state office administrator when the information gathering portion of the investigative process is completed. The investigator informs the administrator or state office administrator that a written report is forthcoming. Preliminary findings are not required.
- (5) **The written investigation report.** After completing the information gathering portion of the investigative process, the OCA investigator prepares a written report containing:
- (A) the allegations investigated, including the date, time, and location of the alleged incidents, the date the allegation was reported to OCA, and the assigned OCA case number;
 - (B) a list of the involved parties, their titles and role in the matter, whether they were interviewed and, if so, when and where;
 - (C) the applicable definition of the type of misconduct at issue, such as discrimination, retaliation, or both;
 - (D) whether the foster parent engaged in an activity listed in (c)(2) in this Section and, if so, a description of the activity;
 - (E) the findings in accordance with OAC 340:2-3-36(l);
 - (F) an explanation of the basis for the finding;

- (G) in cases involving a confirmed finding, a summary of relevant information obtained during each interview conducted during the investigation;
- (H) any areas of concern relating to the allegations that were identified during the investigation regarding practices or procedures of OKDHS or the child placing agency;
- (I) a list of relevant documents and records reviewed during the investigation; and
- (J) a list of attachments to the report.

(6) **Dissemination of the OCA investigative report.**

- (A) In cases involving allegations against an OKDHS employee, the advocate general submits a copy of the final OCA investigation report to the OKDHS Director and the state office administrators.
 - (B) In cases involving an employee of a child placing agency, the advocate general sends a copy of the OCA report to the administrator of the agency and the appropriate state office administrator. If the administrator of the child placing agency is the subject of the report, the report is sent to the agency's board of directors.
 - (C) OCA sends the foster parent and each accused OKDHS employee a letter that summarizes the allegation and states OCA's finding.
 - (D) All parties receiving copies of the investigative reports are bound by the confidentiality provisions of Sections 7005-1.2 and 7107 of Title 10 and Section 10-110 of Title 43A of the Oklahoma Statutes.
- (m) **OKDHS Director's request for review by the Grievance and Abuse Review Committee (GARC).** Within 20 calendar days of receipt of a final OCA investigative report, the OKDHS Director may request GARC to review the allegations and submit a report of its findings in accordance with OAC 340:2-3-63.
- (n) **State office administrator's response to a confirmed finding.**
- (1) When a state office administrator receives a copy of an OCA investigation report containing a finding that an OKDHS employee has engaged in retaliation or discrimination against a foster parent, within 30 calendar days of receipt of the OCA report the state office administrator notifies the advocate general in writing of any personnel action taken or to be taken with regard to the employee, and any corrective action taken or to be taken regarding areas of concern noted in the OCA report.
 - (2) If the OKDHS Director has referred the matter for review by GARC in accordance with subsection (l) of this Section, the state office administrator's response is due within 45 calendar days of GARC's written report to the OKDHS Director.
 - (3) When an administrator of a child placing agency receives a copy of an OCA investigation report containing a finding that an employee of the child placing agency has engaged in retaliation or discrimination against a foster parent, within 30 calendar days of receipt of the report the administrator notifies the advocate general in writing of any personnel action taken or to be taken with regard to

each employee named in the report as having engaged in misconduct, and the status of any areas of concerns noted in the report.

(4) The advocate general reports to the Commission confirmed allegations and corrective action taken.

PART 5. GRIEVANCES

340:2-3-45. Grievance system protocols

(a) **Legal authority, scope, and purpose.**

(1) **Legal authority.**

(A) Section 7004-3.4 of Title 10 of the Oklahoma Statutes confers on the Office of Client Advocacy (OCA) the responsibility to establish and maintain a fair, simple, and expeditious grievance system for complaints filed by or on behalf of children in the custody of the Oklahoma Department of Human Services (OKDHS).

(B) Section 1415.1(A)(2) of Title 10 of the Oklahoma Statutes requires OKDHS to establish an ombudsman program for each institution and residential facility for the mentally retarded operated by OKDHS, including an appeals procedure for the resolution of grievances and complaints of residents, their parents, and their court-appointed guardians. OKDHS has conferred this responsibility on OCA.

(C) OKDHS also has conferred on OCA the responsibility for grievance systems for other clients listed in paragraph (2) of this subsection.

(2) **Scope.** OCA administers and monitors grievance programs for the individuals listed in (A) through (H) of this paragraph, all of whom are collectively referred to as the "client" throughout this Section and OAC 340:2-3-46.

Further detail about grievances for:

(A) minors who are in the custody of OKDHS regardless of placement, refer to OAC 340:2-3-47 through 340:2-3-49;

(B) youth in voluntary care of OKDHS, refer to OAC 340:2-3-49;

(C) foster parents approved by OKDHS, refer to OAC 340:2-3-50;

(D) residents of the Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), and the Greer Center Facility (Greer), refer to OAC 340:2-3-51;

(E) Hissom class members, refer to OAC 340:2-3-52;

(F) other clients receiving services in the community from the Developmental Disabilities Services Division (DDSD) of OKDHS, refer to OAC 340:2-3-53;

(G) residents of group homes for persons with developmental or physical disabilities due to a developmental disability that are subject to Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes, refer to OAC 340:2-3-54; and

(H) clients receiving OKDHS services who want to file a grievance about a problem, concern, or complaint for which there does not exist another grievance system within OKDHS, refer to OAC 340:2-3-55.

(3) **Purpose.** The purpose of OCA's grievance policies and procedures is to provide clients a fair, simple, effective, and timely system of problem resolution with access to procedures through which clients can obtain a thorough review, fair consideration, and correction when appropriate. These policies also ensure that persons filing grievances are free from restraint, coercion, reprisal, or discrimination. To further this purpose, OCA independently reviews and monitors the implementation of grievance programs subject to this Section.

(4) **Informal problem resolution.** Clients have the right to file grievances. However, resolving problems and concerns informally before filing a grievance is encouraged. Not all client inquiries and requests for explanation are considered grievances. Most can be handled within the regular relationship between clients and OKDHS, provider, and facility staff. Efforts are made at the local level to resolve issues and reach a consensus with the client on a plan of action to resolve the problem informally unless the client desires to proceed with the grievance process.

(b) **Definitions.** In addition to the definitions in OAC 340:2-3-2, the following words and terms when used in this Part shall have the following meanings, unless the context clearly indicates otherwise:

(1) **"Area director"** means a director of one of the six service delivery areas designated by OKDHS Field Operations Division (FOD).

(2) **"Area manager"** means a manager of one of the three service delivery areas designated by OKDHS DDSD.

(3) **"Business day" or "working day"** means Monday through Friday, not including federal or state holidays.

(4) **"CFSD"** means the Children and Family Services Division of OKDHS.

(5) **"Client"** means any of the individuals listed in subsection (a) of this Section on whose behalf OCA maintains a grievance system.

(6) **"Contested grievance"** means a grievance that has not been resolved at the local level (first and second levels) and, at the request of the grievant or decisionmaker, is submitted to a higher authority for response.

(7) **"Decisionmaker"** means the person who has authority to decide whether to accept any resolution proposed at each level of the grievance process. It typically is the client who filed the grievance or on whose behalf a grievance was filed. For clients unable to advocate for themselves (for example, young children and persons with severe cognitive limitations), it is a person who speaks on the client's behalf, depending on the circumstances and the nature of the decision to be made.

(A) With regard to minors, it might be a parent, guardian, guardian ad litem, foster parent, or a legal custodian appointed by a court.

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- (B) With regard to DDS clients who are adults, it might be a guardian or the individual support team for the client.
- (8) **"Due date"** means the date by which some response or action is required, for example, the date by when a respondent must respond to a grievance. In calculating the due date, the first day of the period computed is not included and only business days are included. If the last day of the period computed is a Saturday, Sunday, or legal holiday, the period runs until the end of the next business day.
- (9) **"E-mail"** communication with OCA or with the advocate general means an e-mail sent to the e-mail address: *oca.grievances@okdhs.org.
- (10) **"Facility grievance"** means a grievance that involves:
- (A) the substance or application of any policy, rule, or regulation, written or unwritten, of a facility as defined in OAC 340:2-3-2; or
 - (B) a decision, act, or omission of an employee, agent, or contractor of a facility.
- (11) **"FOD"** means the Field Operations Division of OKDHS.
- (12) **"Grievance"** is defined in subsection (c) of this Section.
- (13) **"Grievant"** means a client or the person who files a grievance on behalf of a client.
- (14) **"Local grievance coordinator"** or **"LGC"** means, with regard to:
- (A) minors in OKDHS custody who live in a residential facility, the individual designated by the facility as its grievance coordinator;
 - (B) minors in OKDHS custody who do not live in a residential facility, including minors in foster care and foster parents, the individual designated as grievance coordinator in the OKDHS county office where the grievant resides;
 - (C) DDS clients who are residents of Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Greer Center Facility (Greer), the OCA advocate staff assigned to each facility;
 - (D) foster parents approved by OKDHS, the county director in the OKDHS county office where the grievant resides;
 - (E) DDS clients who are pursuing a grievance with a provider of residential, vocational, or in-home supports, the individual designated by the provider as its grievance coordinator; and
 - (F) all other DDS clients, the applicable DDS area manager or designee.
- (15) **"OCA grievance coordinator liaison"** means the individual(s) designated by the advocate general to coordinate and monitor contested grievances.
- (16) **"OKDHS grievance"** means a grievance that involves:
- (A) the substance or application of any policy, rule, or regulation, written or unwritten, of OKDHS (other than policies, rules, and regulations of OKDHS operated shelters and residential facilities for minors); or
 - (B) a decision, act, or omission of an employee of OKDHS, including but not limited to a Child Welfare (CW) specialist, a case manager, and OKDHS county directors, but not including an employee of an OKDHS operated facility.
- (17) **"Placement grievance"** means a complaint about a present or proposed placement of a minor in OKDHS custody.
- (18) **"Respondent"** means the person at each level in the grievance process who has the responsibility for reviewing the grievance and proposing a resolution to resolve the grievance.
- (c) **Grievance defined.**
- (1) **"Grievance"** means a problem or concern that an individual needs assistance resolving, including a complaint of unfair treatment. At the request of a client, an unresolved problem, concern, complaint, or dispute is processed as a grievance. When a client verbally communicates a complaint to an OKDHS employee or a facility or provider employee that is not resolved, the client is informed of the right to have the problem or concern processed as a grievance. At the request of the client, the employee prepares a written statement of the client's complaint or refers the client to the local grievance coordinator to assist in doing that.
- (A) **Facility or provider grievances.** The subject of a facility grievance or a provider grievance includes:
 - (i) the substance or application of any policy, rule, or regulation, written or unwritten, of an OKDHS operated shelter or residential facility for minors, or a facility, agency, or provider which contracts with OKDHS, or a child placing agency; or
 - (ii) a decision, act, or omission of an employee, agent, or contractor of such a facility, or any client residing in the same placement setting.
 - (B) **OKDHS grievances.** The subject of an OKDHS grievance includes:
 - (i) the substance or application of any policy, rule, or regulation, written or unwritten, of OKDHS, but this does not include policies, rules and regulations of OKDHS operated shelters and residential facilities for minors;
 - (ii) a decision, act, or omission of an employee in an OKDHS operated facility; this includes a case manager, a CW specialist, and county office employees; or
 - (iii) a facility grievance filed by a resident of SORC, NORCE, or Greer.
 - (C) **Placement grievances.** A placement grievance is defined in subsection (b) of this Section.
- (2) **Summary dispositions.** If a grievance is submitted and it falls into one of the categories listed in (A) through (K) of this paragraph, when appropriate, the LGC

contacts the client to provide assistance to the client in rewriting the grievance to state the problem(s) or concern(s) the client wants to grieve. If it is determined the client is asking to grieve a problem or concern covered by any of the categories below, the LGC informs the client why the grievance is not being processed, using Form ~~OCA-GR-8-15GR012E~~, Notice of Summary Disposition of Grievance - OKDHS County Offices, ~~OCA-GR-8-A-15GR013E~~, Notice of Summary Disposition of Facility Grievance - ~~DDSD Clients~~, ~~OCA-GR-8-B-15GR014E~~, Notice of Summary Disposition of Facility Grievance - ~~Developmental Disabilities Services Division (DDSD) Clients~~, ~~OCA-GR-8-C-15GR015E~~, Notice of Summary Disposition of Developmental Disabilities Services Division (DDSD) Provider Grievance, or 15GR016E, Notice of Summary Disposition of Foster Parent Grievance, whichever is applicable. The LGC also writes the reason on the bottom of Form ~~OCA-GR-1-15GR001E~~, Grievance Form, and then dates and signs the form. The grievance is logged on ~~the grievance tracking log Form 15GR009E~~, Grievance Tracking Log. The form used to notify the grievant along with a copy of the grievance form is sent within ~~two~~ three business days to the advocate general for review, and the original is filed in the appropriate grievance file. Within three business days of receipt, the OCA grievance coordinator reviews the grievance. If the OCA grievance ~~coordinator~~ liaison determines the grievance was improperly given a summary disposition, the OCA grievance ~~coordinator~~ liaison informs the LGC who immediately processes the grievance. If the OCA grievance ~~coordinator~~ liaison concurs with the summary disposition, the OCA grievance ~~coordinator~~ liaison informs the LGC in writing.

(A) **Untimely grievances.** A grievance which is not timely filed in accordance with OAC 340:2-3-45(g) can be accepted and processed when good cause exists for the delay in filing the grievance. There are no time limits for filing grievances on behalf of individuals served by the OKDHS DDSD.

(B) **Discrimination based on race, color, national origin, sex, age, religion, or disability.** If a grievance alleges discrimination or other civil rights matters, the client is referred to the OKDHS Office for Civil Rights and the LGC immediately forwards the grievance to the OKDHS civil rights administrator and so informs the grievant.

(C) **A problem which that is moot.** A moot problem is one that already has been decided or settled or one that has no practical resolution. For example, a placement grievance with regard to a child who is no longer in OKDHS custody; or a grievance with regard to an event that was in future but is now in the past, when the dispute about the event is unlikely to occur again with regard to this client.

(D) **Duplicative grievances.** This is a grievance which duplicates another pending grievance in the same grievance system by or on behalf of the client involving the same incident or problem.

(E) **Requests to violate laws.** This is a grievance which requests an action that violates state or federal law.

(F) **Collateral complaint.** A collateral complaint does not involve a problem concerning the client who filed or on whose behalf the grievance was filed.

(G) **Remote grievances.** The grievance requires action by a private or public individual or entity over which OKDHS does not have authority or control, such as a grievance about the action of a public school teacher, a guardian, or a physician in private practice. In these situations, the LGC assists the grievant in using any grievance or complaint system which may be available regarding the subject of the grievance.

(H) **Pending proceedings.** The grievance involves a matter which is the subject of a pending civil, criminal, or administrative proceeding, or a decision of a court or administrative hearing, or the subject of a pending OCA, Office of Inspector General (OIG), or Child Welfare investigation.

(I) **Investigative findings.** The results of an investigation regarding abuse, neglect, verbal abuse, caretaker misconduct, or exploitation cannot be grieved.

(J) **Fair hearing decisions.** The results of a fair hearing cannot be grieved pursuant to OAC 340:2-5-50.

(K) **Frivolous grievances.** A frivolous grievance does not state a complaint or problem of any substance. Before declining to process a grievance of this nature, the LGC contacts the grievant to inquire if the grievant needs assistance in submitting a substantive grievance.

(3) **Documenting exclusions.** If a grievance is submitted and it falls into an excluded category listed in the preceding paragraph, the LGC dates and signs Form ~~OCA-GR-1-15GR001E~~ as received, and notes on the form the reason the LGC does not process it. The grievant is informed of this decision and the reason. The grievance is logged in the grievance tracking log and the form is filed in the client's grievance file. The LGC sends a copy of the Form ~~OCA-GR-1-15GR001E~~ and a copy of the applicable Notice of Summary Disposition to the advocate general, or designee, for review.

(4) **Who may file a grievance.** A grievance may be filed by any client listed in subsection (a) of this Section. A grievance may also be filed by or on behalf of a client by any person who knows the client and is interested in the client's welfare, including, but not limited to, a parent, guardian, relative, foster parent, court appointed special advocate, guardian ad litem, case manager, personal support team member, job coach, and others. This includes OKDHS employees and employees of residential, in-home supports, and vocational providers.

(5) **Group grievances.** Grievants whose complaints address the same issue(s) may together file a group grievance. At any time during the processing of a group grievance, an individual grievant can withdraw from the

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group grievance. If separate grievances are filed by two or more grievants regarding an identical issue, the interests of each grievant is identical, and the grievants do not object, a LGC can combine them for processing as a group, provided this does not unduly delay the processing of any particular grievance. When multiple grievances are grouped for processing, the LGC informs each grievant of that action. When a group grievance is filed, the LGC can ask the grievants to designate in writing a spokesperson for the group.

(6) **Grievances involving reportable incidents.** When a grievance alleges a reportable incident, including but not limited to, facts which constitute abuse, neglect, exploitation, or caretaker misconduct, as defined in OAC 340:2-3-2, the LGC immediately reports it to OCA intake pursuant to OAC 340:2-3-33. A grievance involving a reportable incident may be processed during a pending investigation provided the grievance does not interfere with the investigation and as needed is held in abeyance pending the conclusion of the investigation. If the grievance alleges additional facts which do not constitute abuse, neglect, exploitation, or caretaker misconduct, the grievance is processed as to those facts. The LGC contacts OCA and any other law enforcement agency investigating the matter to coordinate processing the grievance.

(d) **Grievance policies required.** Every provider and facility providing services to a client listed in OAC 340:2-3-45(a)(2) who is living in Oklahoma is required to operate a system for resolution of grievances by clients using policies and procedures meeting the requirements of this Part.

(1) **Designation of LGC.**

(A) Every public and private facility and provider subject to this Part, OKDHS county office, and DDS area office designates an employee to serve as LGC to carry out the responsibilities described in this Section. Facilities and providers inform the advocate general of the name, phone number, mailing address, and e-mail address of their LGC, and inform the advocate general of any changes within 30 calendar days of the effective date of a change by completing Form ~~OCA-GR-10~~ 15GR021E, Designation of Local Grievance Coordinators, Facility and Provider Agencies, and submitting it to the Office of Client Advocacy. OCA's advocates assigned to SORC, NORCE, and Greer serve as the LGC at those facilities. The LGC is an individual who:

- (i) implements grievance policies and procedures;
- (ii) has experience with the programs and functions of the facility, provider, county office, or DDS area office;
- (iii) functions impartially and independently in the processing of grievances;
- (iv) reports directly to the administrator with regard to the LGC's grievance duties and functions;
- (v) within 60 calendar days of being designated LGC, completes the online OCA Grievance Course; and

(vi) ensures that client requests regarding how to file a grievance are responded to within two business days.

(B) Each facility and provider subject to this Part, each OKDHS county office, and each DDS area office displays in a place conspicuous to its clients a poster notifying clients of its grievance system and the name of its local grievance coordinator, using Form ~~OCA-GR-9~~ 15GR017E, Grievance Poster - Child Welfare Contracted Facilities, Form ~~OCA-GR-9-A~~ 15GR018E, Grievance Poster-~~OKDHS~~ Oklahoma Department of Human Services (OKDHS) County Offices, ~~or Form OCA-GR-9-B~~ 15GR019E, Grievance Poster - ~~DDS~~ Developmental Disabilities Services Division Providers, or 15GR020E, Grievance Poster - Oklahoma Department of Human Services (OKDHS) Developmental Division Services Division (DDS) Offices, whichever is applicable.

(2) **Advocate general review of grievance programs.** The grievance system operated by each facility and provider subject to this Part is subject to the approval of the advocate general. Each provider and facility other than an OKDHS operated facility is required to submit to the advocate general for approval its grievance policies, procedures, forms, and any revisions which are adopted, along with proof that the policies or revisions have been approved by the applicable approving authority. Revised policies are submitted to the advocate general for approval within 30 days of the provider or facility adopting the revised policy.

(3) **Notifying clients of their grievance rights.** Each client covered by these grievance policies is notified of his or her right to and how to access the grievance resolution procedures using Form ~~OCA-GR-2~~ 15GR004E, Notice of Grievance Rights - Minors in OKDHS Custody, Form ~~OCA-GR-2-A~~ 15GR005E, Notice of Grievance Rights - Minors in OKDHS Custody - Youth in Voluntary OKDHS Care, Form ~~OCA-GR-3~~ 15GR006E, Notice of Grievance Rights - DDS Clients (General), Form ~~OCA-GR-3-A~~ 15GR007E, Notice of Grievance Rights - Hisson Class Members, or Form ~~OCA-GR-4~~ 15GR008E, Notice of Grievance Rights - Foster Parents, whichever is applicable. Hisson class members are provided notice in accordance with OAC 340:2-3-52. In addition, providers are encouraged to provide a simplified version of their grievance policies using language appropriate to the age level and cognitive functioning of its clients.

(4) **Monitoring and evaluation.** OCA ensures the quality of grievance systems by establishing minimum standards and through an ongoing monitoring program. The advocate general and OCA staff have immediate and unlimited access to clients, staff, and facility files, records, and documents relating to grievance procedures and practices.

(5) **Reporting deficiencies.** An LGC who becomes aware of a deficiency in a grievance system, including a failure to follow or implement the grievance policy, must report it to the advocate general by

phone at 1-405-525-4850 or 1-800-522-8014, fax at 1-405-525-4855, or e-mail.

(6) **Advocate general deficiency report.** If the advocate general determines a deficiency exists in the grievance system of a facility or provider, the advocate general sends a report of deficiency to the administrator and, where applicable, to the state office administrator.

(7) **Advocate general grievance.** The advocate general may, on behalf of any or all clients served by the grievance policy in this Section, originate a grievance. An advocate general grievance is filed with the administrator or the state office administrator and processed as a contested grievance.

(8) **Advocate general report.**

(A) The advocate general may initiate an inquiry on behalf of any client as defined in subsection (a) of this Section regarding:

- (i) any aspect of the care of a client that affects the quality of the client's life;
- (ii) the substance, application, or interpretation of any policy, rule, or regulation, written or unwritten, of OKDHS operated shelter or residential facility, or a facility or agency that contracts with OKDHS, or a placement provider; or
- (iii) any decision, behavior, or action of an employee, agent, or contractor of OKDHS, or of any client residing in the same placement setting.

(B) The person to whom the advocate general inquiry is addressed has seven business days to respond in writing to the advocate general.

(C) The advocate general issues a report which sets forth the subject matter of the inquiry, the pertinent facts, and recommendations. An advocate general report is submitted to the administrator, when applicable, and the state office administrator. A copy is submitted to the OKDHS Director.

(e) **The grievance form.** A grievant files a grievance by obtaining from the LGC Form ~~OCA-GR-1~~ 15GR001E, filling it out, and turning it in to the LGC or to any facility or OKDHS staff, who immediately transmits it to the LGC.

(1) LGCs obtain copies of this form from the OCA in Oklahoma City, 1-405-525-4850 or 1-800-522-8014.

(2) Any person who needs assistance in completing the grievance form is given assistance by the LGC or any other staff member.

(3) A grievance received on paper other than Form ~~OCA-GR-1~~ 15GR001E is attached to a Form ~~OCA-GR-1~~ 15GR001E filled out by the LGC on behalf of the grievant.

(f) **Retaliation prohibited.** No person filing a grievance shall be retaliated or discriminated against or harassed, solely or in part, for having asserted a grievance, or sought advice or inquired about filing a grievance. Clients are encouraged to use available grievance systems. Clients are not discouraged from filing a grievance.

(g) **Grievance time limits.** Except for DDS clients, in order to be processed for action and resolution, a grievance must be filed within 15 business days of the date of the incident, decision, act, or omission complained about in the grievance,

or within 15 business days of the date the grievant becomes aware of or, with reasonable effort, should have become aware of a grievable issue. The time limit for filing a grievance may be extended by the LGC. When a foster parent requests an extension in order to pursue mediation through the Oklahoma Commission on Children and Youth (OCCY) Foster Parent Mediation Program as provided in Section 601.6 of Title 10 of the Oklahoma Statutes, an LGC must grant the requested extension. The grievance is then not processed until the mediation has been completed, and grievance timeframes are suspended for the duration of the mediation. When mediation resolves the original grievance, the foster parent(s) may withdraw the grievance, or the LGC may declare the grievance "administratively resolved" consistent with OAC 340:2-3-45(h).

(1) The filing time and all other time periods contained in this Section are counted in business days unless otherwise specified. In computing any period of time, the day of the incident, decision, act, or omission at issue is not included. The next calendar day is the first day of the time period.

(2) If the LGC or any respondent fails to meet any time limit for processing a grievance without obtaining an extension, the LGC processes the grievance to the next step within ~~two~~ three business days of the grievant's request.

(3) Responses, notices, and other documents issued during the processing of a grievance are delivered to the grievant in person or by mail at the last known address of the grievant. A grievance is considered administratively resolved when a correctly addressed letter sent to the last known address of the grievant with proper postage is returned undeliverable with no forwarding address.

(4) There is no time limit on allegations of abuse, neglect, verbal abuse, exploitation, or caretaker misconduct. If a grievance, timely or untimely, consists of such an allegation, OCA intake is immediately notified in accordance with OAC 340:2-3-33.

(h) **Grievance records, logs, and quarterly reports.**

The LGC maintains an accurate and complete record of each grievance filed as well as summary information about the number, nature, and outcome of all grievances filed. Records of grievances are kept separate and apart from other client records and files. Grievance records relating to DDS clients are retained in accordance with OAC 340:100-3-40. OKDHS grievance records and files are retained in accordance with state and federal laws governing retention and destruction of records.

(1) Each LGC tracks grievances as they progress through the system and keeps a log of every numbered grievance form issued by OCA. Form ~~OCA-GR-5~~ 15GR009E, Grievance Tracking Log, can be used for this purpose. For grievances submitted by a client, the tracking log includes: the grievance number; the name of the grievant given the form; the date the form was submitted by the grievant; the nature and outcome of the grievance; the date of final resolution; and the level where it was resolved. If a grievance form is provided to a client and not turned in, the facility tracks only the number on the

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form, the name of the client to whom the form was given, and the date it was given to the client.

(2) Each LGC submits to the advocate general a quarterly grievance report, Form ~~OCA-GR-6~~ 15GR010E, Quarterly Grievance Report. The quarterly report is transmitted to the advocate general no later than the 21st day following the end of each calendar quarter. Quarterly reports are submitted by mail, fax, or e-mail. ~~When no grievance activity occurred or was pending during a particular calendar quarter, the LGC can inform the advocate general of this by e-mail in lieu of submitting Form OCA-GR-6.~~ The e-mail address is: *oca.grievances@okdhs.org. When no grievance activity occurred or was pending during a particular fiscal year quarter, the LGC so indicates on Form 15GR010E.

(3) If a grievance becomes moot at any point during the processing of the grievance, the LGC can stop the grievance process and declare the grievance "administratively resolved." The LGC informs the grievant, notes it on the applicable Form ~~OCA-GR-1~~ 15GR001E and Form 15GR009E and the tracking log, and sends a copy of Form ~~OCA-GR-1~~ 15GR001E to OCA with the next quarterly grievance report.

(i) **Processing the grievance form.** After completing Form ~~OCA-GR-1~~ 15GR001E, the grievant submits the form directly to the LGC or any other employee of the facility or OKDHS. Form ~~OCA-GR-1~~ 15GR001E is printed in duplicate sets with a carbonless yellow copy. The grievant submits the white copy and keeps the yellow copy. If someone other than the LGC receives a grievance, that person submits it directly to the LGC within one business day of receipt.

(j) **Informal resolution of grievance.** If the LGC is able to promptly resolve the grievance to the grievant's satisfaction without further processing, the LGC fills out the bottom of Form ~~OCA-GR-1~~ 15GR001E, signs it, and files it in the appropriate grievance file.

(k) **First level problem resolution.** Within three business days of receipt of Form ~~OCA-GR-1~~ 15GR001E, if the grievance has not been resolved to the grievant's satisfaction, the LGC fills out Form ~~OCA-GR-1-A~~ 15GR002E, Local Grievance Coordinator (LGC) Worksheet.

(1) The LGC identifies who has the authority to provide the quickest and surest resolution to the problem at the lowest level in the organizational structure.

(A) For OKDHS grievances of minors in OKDHS custody and youths in voluntary OKDHS care, the first level respondent may be the supervisor of the grievant's Child Welfare specialist.

(B) For grievances regarding placements above the therapeutic foster care level made by Children and Family Services Division (CFSD) placement services, the respondent is the applicable CFSD programs manager.

(C) For placement grievances regarding a specific foster child, the respondent is the applicable county director.

(D) If the minor also is a DDS case manager, this may be the DDS case manager supervisor.

(E) For adults receiving services from DDS, the first level respondent may be the DDS case manager supervisor.

(2) The LGC completes the first box in the first level section on Form ~~OCA-GR-1-A~~ 15GR002E, attaches the corresponding Form ~~OCA-GR-1~~ 15GR001E, and other relevant documentation and information, and submits it to the first level respondent, by the most efficient means practicable, within three business days of receipt of the grievance from the grievant.

(3) The first level respondent responds to the grievance within five business days of receipt of Form ~~OCA-GR-1-A~~ 15GR002E by completing the second box in the first level section on Form ~~OCA-GR-1-A~~ 15GR002E. If the proposed resolution contains a promise of some future action, a target date is specified for full implementation of that future action. The grievant can contest the target date by taking the grievance to the next level of problem resolution.

(4) The LGC monitors the timely response by the first level respondent. If a complete response is not timely received by the LGC, the LGC notes this on Form ~~OCA-GR-1-A~~ 15GR002E, and the grievance immediately proceeds to the second level of problem resolution.

(5) Within three business days of receipt of the first level response, the LGC or designee contacts the grievant to inform the grievant of the proposed resolution and the right to take the grievance to the second level of problem resolution, and determines if the grievant is satisfied with the proposed resolution. The first level respondent may meet with the grievant with or without the LGC. If the grievant needs time to decide whether to accept the proposed resolution, the grievant has ~~two~~ three business days within which to make a decision. If no decision is communicated to the LGC within ~~two~~ three business days, the grievant is deemed to have accepted the proposed resolution. The LGC is responsible for informing grievants that they have three business days in which to accept or to appeal the respondent's proposed resolution.

(6) If the grievant is satisfied with the proposed resolution, the LGC indicates the grievant's acceptance on Form ~~OCA-GR-1-A~~ 15GR002E, notifies the individuals responsible for resolution of the grievance, and places the form in the appropriate grievance file.

(7) If the proposed resolution has been accepted by the grievant but involves a target date in the future, the LGC monitors compliance with the target date. If the LGC determines that the resolution has not been achieved by the target date, the LGC immediately reopens the grievance and processes it for second level of problem resolution.

(8) If the grievant does not accept the proposed resolution and desires to take the grievance to the second level of problem resolution, the LGC processes the grievance for the second level of problem resolution in accordance with subsection (1) of this Section.

(1) **Second level problem resolution.**

(1) If the grievance is not resolved at the first level of problem resolution, the LGC processes it in accordance

with this subsection within three business days of the grievant requesting the second level of problem resolution pursuant to subsection (k) of this Section.

(2) The LGC fills out the first box in the second level section on Form ~~OCA-GR-1-A-15GR002E~~, ensures the corresponding Form ~~OCA-GR-1-15GR001E~~ and other relevant documents are attached, and submits it immediately to the second level respondent. For facilities and providers subject to these rules, the administrator or designee is the second level respondent. For OKDHS grievances, the OKDHS county director or the DDS area manager, whichever is applicable, is the second level respondent. If the administrator, county director, or DDS area manager was the first level respondent, then the second level of problem resolution is skipped and the grievance is processed as a contested grievance pursuant to subsection (m) of this Section.

(3) The administrator or designee responds to the grievance within seven business days of receipt of Form ~~OCA-GR-1-A-15GR002E~~ by completing the applicable box in the second level section on Form OCA-GR-1-A. If the proposed resolution contains a promise of some future action, a target date is specified for full implementation of that future action.

(4) The second level respondent for a placement grievance regarding a specific foster child is the applicable area director.

(5) The LGC monitors the timely response by the respondent. If a complete response is not timely received by the LGC, the LGC notes this on Form ~~OCA-GR-1-A-15GR002E~~ and the grievance immediately is processed as a contested grievance. A contested OKDHS grievance is processed in accordance with OAC 340:2-3-46. Contested facility grievances are processed in accordance with subsection (m) of this Section.

(6) Within three business days of receipt of the second level response, the LGC contacts the grievant to inform the grievant of the proposed resolution and the right to contest the response to the grievance, and determines if the grievant is satisfied with the proposed resolution. If the grievant needs time to decide whether to accept the proposed resolution, the grievant has ~~two~~ three business days within which to make a decision. If no decision is communicated to the LGC within two business days, the grievant is deemed to have accepted the proposed resolution.

(7) If the grievant is satisfied with the proposed resolution, the LGC indicates the grievant's acceptance on Form ~~OCA-GR-1-A-15GR002E~~, notifies the individuals responsible for resolution of the grievance, and places the form in the appropriate grievance file.

(8) If the proposed resolution has been accepted by the grievant but involves a target date in the future, the LGC monitors compliance with the target date. If the LGC determines that the resolution has not been completed by the target date, the LGC immediately reopens the grievance and processes it as a contested grievance.

(9) If the grievant does not accept the proposed resolution and indicates a desire to contest the response, a contested OKDHS grievance is processed in accordance with OAC 340:2-3-46. Contested facility grievances are processed in accordance with subsection (m) of this Section.

(m) **Contested facility or provider grievances.** If the grievant does not accept the proposed resolution or the target date of the second level proposed resolution, or both, a facility or provider grievance is appealed to the chair of the board of directors of the facility or provider or an appeals committee designated by the board. This section does not apply to grievances of Hissom class members. Grievances at OKDHS operated facilities are appealed as a contested grievance in accordance with OAC 340:2-3-46.

(1) The LGC transmits a contested facility or provider grievance to the chair of the board of directors of the facility or provider, or an appeals committee designated by the board, within three business days of learning that the grievant does not accept the proposed resolution and is contesting the proposed resolution.

(2) In reviewing the contested grievance, the board of directors, or appeals committee if applicable, is not required to hold a hearing to hear evidence or arguments. In the event the board determines that hearing evidence would assist it in resolving the grievance, the board has the option of holding a hearing. If it does so, the hearing does not require the formalities of a fair hearing.

(3) Within ten business days of receiving a contested grievance, the chair of the board of directors or the appeals committee responds to the grievant by submitting a written decision to the LGC.

(4) Within three business days of receiving the written decision of the chair of the board of directors or the appeals committee, the LGC informs the grievant of that decision and provides the grievant with a copy of the board's written decision. This concludes the grievance process and the grievant's administrative remedies have been exhausted.

(n) **Fast track grievances.** When the subject of an OKDHS grievance is such that time is of the essence, with the approval of the advocate general or designee a grievance can be submitted directly to the OCA grievance ~~coordinator~~ liaison for processing as a contested grievance in accordance with OAC 340:2-3-46. When a grievance involves a time sensitive problem, the OCA grievance ~~coordinator~~ liaison can shorten the time for responding as warranted by the circumstances.

(o) **Communications with OCA.** Any notices, forms or other information that facilities, providers, or OKDHS county offices are required to submit to OCA or the advocate general can be submitted by e-mail, using the e-mail address *oca.grievances@okdhs.org.

(p) **Grievance training required.** LGCs are required to take the OCA online grievance training within 60 days of their appointments, and annually thereafter.

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340:2-3-46. Contested grievances appealed to the state office

(a) **Application.** This Section describes the processes for contesting the second level response to Oklahoma Department of Human Services (OKDHS) grievances, facility grievances at OKDHS operated facilities, and provider grievances of Hisssom class members.

(b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-45(b) apply to this Section unless the context clearly indicates otherwise.

(c) **Initiating the contested grievance.** When a grievant asks to appeal a grievance to the state office administrator, within three business days of being informed of that request, the local grievance coordinator (LGC) transmits to the Office of Client Advocacy (OCA), Attn. OCA grievance ~~coordinator~~ liaison, Form ~~OCA-GR-1-A 15GR002E~~, Local Grievance Coordinator (LGC) Worksheet, attaching the corresponding Form ~~OCA-GR-1 15GR001E~~, Grievance Form, and other documents and information relevant to the subject matter of the grievance.

(d) **Documentation requirements.** When Form ~~OCA-GR-1-A 15GR002E~~ is submitted to OCA, it has attached:

- (1) the corresponding Form ~~OCA-GR-1 15GR001E~~;
- (2) supporting facts relating to the proposed resolution by the second level respondent, including documentation relating to the first level and second level of problem resolution processes; and
- (3) any written rule, policy, procedure, regulation, and other information relevant to the subject matter of the grievance.

(e) **OCA processing of grievance.** Within three business days of OCA's receipt of a contested grievance, OCA reviews the contested grievance and accompanying documentation and determines if any additional information is necessary for disposition of the appeal. When any information appears to be missing, OCA contacts the person(s) in possession of the needed information and sets deadlines for submission of the information by the most efficient means to avoid delays in processing the contested grievance.

(f) **Rejected grievances.** If OCA determines the subject matter of a grievance falls in one of the categories listed in OAC 340:2-3-45(c)(2), OCA returns the grievance to the LGC with a cover letter indicating the reason the grievance was not accepted for processing as a contested grievance. Within ~~two~~ three business days of receipt of OCA's letter, the LGC contacts the grievant to inform the grievant of the status of the grievance.

(g) **OCA transmittal to state office administrator.** Within three business days of OCA's receipt of a contested grievance and all documents required by subsection (d) of this Section, the advocate general or designee prepares and sends Form ~~OCA-GR-7 15GR011E~~, Contested Grievance Transmittal, to the state office administrator with decision-making authority to respond to the subject of the grievance.

(h) **State office administrator's response.** The state office administrator who receives a contested grievance responds to the grievant within ten business days. The advocate general or designee may grant an extension when good cause is

shown, such as the complexity of the issues. The state office administrator sends his or her response directly to the LGC after completing the middle portion of Form ~~OCA-GR-7 15GR011E~~, Contested Grievance Transmittal. A copy is sent to the advocate general. The state office administrator attaches his or her response to Form ~~OCA-GR-7 15GR011E~~ and includes:

- (1) the proposed resolution and how it is to be implemented;
- (2) the person(s) responsible for implementing the proposed resolution;
- (3) the target date for the proposed resolution;
- (4) facts which support the appropriateness of the proposed resolution by the facility, including relevant documentation; and
- (5) any written rule, policy, procedure, regulation, and other information relevant to the subject matter of the grievance and the proposed resolution.

(i) **Timely response required.** The OCA grievance ~~coordinator~~ liaison monitors the timely response by the state office administrator. If a complete response is not timely received by the OCA grievance coordinator and an extension has not been granted, the OCA grievance ~~coordinator~~ liaison immediately processes the grievance for review by the Grievance and Review Committee (GARC) in accordance with OAC 340:2-3-64(b). In that event, OCA notifies the grievant and affected state office administrator that the grievance is being processed for GARC.

(j) **Presentation of proposed resolution.** The LGC or designee contacts the grievant within ~~two~~ three business days of receipt by the LGC of the state office administrator's response. If the grievant accepts the proposed resolution, the LGC notes this on the OCA transmittal memo and files it in the client's grievance file.

(k) **Request for GARC review.** If the grievant does not accept the response of the state office administrator, the LGC completes the bottom portion of Form ~~OCA-GR-7 15GR011E~~ and returns it to the OCA grievance ~~coordinator~~ liaison within ~~two~~ three business days. Upon receipt by OCA of Form ~~OCA-GR-7 15GR011E~~, the grievance is processed for review by GARC in accordance with OAC 340:2-3-64.

340:2-3-47. Grievances of minors in OKDHS custody living in private residential facilities

(a) **Application.** This Section describes processes relating to grievances of minors in the Oklahoma Department of Human Services (OKDHS) custody who are residing in a private residential child care center which contracts with OKDHS.

(b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-45(b) apply to this Section unless the context clearly indicates otherwise.

(c) **Notice of grievance rights.** The applicable Child Welfare liaison gives Form ~~OCA-GR-2 15GR004E~~, Notice of Grievance Rights - Minors in OKDHS Custody, to the client within 24 hours of placement of the client in a private residential placement, and annually thereafter. This form is used to identify the local grievance coordinator (LGC) and to explain the client's right to grieve. After the client signs the form, a

copy is made for the client and the original is maintained in the permanent record for the client.

(d) **Filing and processing of grievance at the facility.** If the grievant files a facility grievance as defined in OAC 340:2-3-45(b), the grievance is processed in accordance with OAC 340:2-3-45 unless otherwise provided in this Section.

(e) **Contested grievances.** Contested OKDHS grievances of residents are processed in accordance with OAC 340:2-3-46. Contested facility grievances are processed in accordance with this subsection. When a grievant in a private residential facility asks to appeal a grievance, within three business days of that request the LGC transmits to the chair of the facility's board of directors, or an appeals committee designated by the board, Form ~~OCA-GR-1A~~ 15GR002E, Local Grievance Coordinator (LGC) Worksheet, which has attached to it the corresponding Form ~~OCA-GR-1~~ 15GR001E, Grievance Form, and other documents and information relevant to the subject matter of the grievance. The chair of the board of directors or appeals committee responds within ten business days by sending a written response to the LGC. A copy is attached to the applicable quarterly grievance report sent to the OCA grievance coordinator ~~liaison~~ in accordance with OAC 340:2-3-45(h)(2). Within ~~two~~ three calendar days of receipt of the response, the LGC communicates the response to the grievant. This concludes the grievance process and the grievant's administrative remedies have been exhausted.

340:2-3-48. Grievances of minors in OKDHS operated shelters and group homes

(a) **Application.** This Section describes processes relating to grievances of minors in DHS custody who are residing in a DHS operated shelter or residential facility.

(b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-45(b) apply to this Section unless the context clearly indicates otherwise.

(c) **Notice of grievance rights.** Form ~~OCA-GR-2~~ 15GR004E, Notice of Grievance Rights: Minors in DHS Custody, is given to the client within 24 hours of placement of the client in the facility by the shelter or group home CW Specialist. This form is used to identify the local grievance coordinator and to explain the client's right to grieve. After the client signs the form, a copy is given to the client and the original is maintained in the permanent record for the client.

(d) **Filing and processing of grievance at the facility.** If the grievant files a facility grievance as defined in OAC 340:2-3-45(b), the grievance is processed in accordance with OAC 340:2-3-45 unless otherwise provided in this Section.

(e) **Contested grievances.** Contested grievances of residents are processed in accordance with OAC 340:2-3-46 unless otherwise provided in this Section. When a grievant in a DHS operated shelter or residential facility asks to appeal a grievance, the appeal is processed in accordance with OAC 340:2-3-46.

340:2-3-49. Grievances of minors in OKDHS custody and youth in voluntary care living in other residential settings

(a) **Application.** This Section describes processes relating to grievances of minors in Oklahoma Department of Human Services (OKDHS) custody who are residing in their own home, minors in OKDHS custody and youth in voluntary care in any type of foster care, and minors in OKDHS custody or youth in independent living who want to file an OKDHS grievance.

(b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-45(b) apply to this Section unless the context clearly indicates otherwise.

(c) **Notice of Grievance Rights.** The assigned Child Welfare worker gives Form ~~OCA-GR-2~~ 15GR004E, Notice of Grievance Rights - Minors in OKDHS Custody, to the placement provider and to the client upon placement of the client, and annually thereafter. This form is used to identify the local grievance coordinator and to explain the client's right to grieve. After the client signs the form, a copy is given to the client and the original is maintained in the permanent record for the client.

(d) **Filing and processing of grievance.** If the grievant files an OKDHS grievance as defined in OAC 340:2-3-45(b), the grievance is processed in accordance with OAC 340:2-3-45 unless otherwise provided in this Section.

(e) **Contested grievances.** Contested grievances of residents are processed in accordance with OAC 340:2-3-46 unless otherwise provided in this Section. When a grievant asks to appeal an OKDHS grievance, the appeal is processed in accordance with OAC 340:2-3-46.

340:2-3-50. Grievances of foster parents

(a) **Application.** This Section describes processes relating to grievances of foster parents approved by the Oklahoma Department of Human Services (OKDHS). Section 7213 of Title 10 of the Oklahoma Statutes confers on OKDHS the responsibility to establish grievance procedures for foster parents with whom state agencies or child placing agencies contract.

(b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-45(b) apply to this Section unless the context clearly indicates otherwise.

(c) **Notice of grievance rights.** Form ~~OCA-GR-4~~ 15GR008E, Notice of Grievance Rights - Foster Parents, is given to each foster parent when approved as an OKDHS foster parent and at reassessment. It is given to the foster parent by the Child Welfare (CW) worker assigned to the foster home within two business days of the approval or the reassessment. This form is used to identify the local grievance coordinator (LGC) and to explain the foster parent's right to grieve. After the foster parent signs the form, a copy is given to the foster parent and the original is maintained in the permanent record for the foster parent.

(d) **Grievance defined.** Foster parents may file grievances with respect to the provision or receipt of services.

(1) **Grievable issues.** Except for the limitations listed in subsection (d)(2) of this Section, matters which can be the subject of a grievance include:

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- (A) the substance or application of any policy, rule, or regulation, written or unwritten, of OKDHS; or
- (B) a decision, act, or omission of an employee of OKDHS.
- (2) **Summary dispositions.** If it is determined that the foster parent is asking to grieve a problem or concern covered by any of the categories in Section OAC 340:2-3-45(c)(2) or by any of the categories listed in (A) through (F), the LGC informs the foster parent why the grievance is not being processed, using Form ~~OCA-GR-8-D~~ 15GR016E, Notice of Summary Disposition of Foster Parent Grievance. In addition to the categories in Section OAC 340:2-3-45(c)(2), situations that are not grievable by foster parents under this grievance system are:
- (A) a decision of a court;
- (B) findings of a child abuse and neglect investigation or assessment in a foster home. The process for appealing these findings is found at OAC 340:75-1-12.2;
- (C) disposition of a fair hearing regarding closure of a foster home. The fair hearing process regarding closure of a foster home is found at OAC 340:75-7-94;
- (D) disputes with other foster parents;
- (E) written plans of compliance. The foster parents provide their written input on the compliance documentation; and
- (F) replacement of a child in a foster home after removal due to a child abuse or neglect investigation. The fair hearing process regarding replacement in foster care is found at OAC 340:75-1-12.6.
- (3) **Grievances alleging retaliation.** Grievances alleging retaliation or discrimination, as those terms are defined in OAC 340:2-3-38(b), are processed in accordance with that Section.
- (4) **Grievances alleging discrimination.** If a grievance alleges discrimination based on sex, age, national origin, religion, color or disability, the grievant is referred to the OKDHS Office for Civil Rights and the LGC immediately forwards the grievance to the OKDHS civil rights administrator, and so informs the grievant.
- (e) **Filing and processing of grievance.** A grievance filed by a foster parent is processed as an OKDHS grievance in accordance with OAC 340:2-3-45 unless otherwise provided in this Section.
- (1) The county director serves as the LGC for grievances filed by foster parents. For grievances involving specialized foster care, the applicable Developmental Disabilities Services Division (DDSD) area manager or designee serves as the LGC.
- (2) Foster parent grievances must be filed within 45 calendar days of the occurrence.
- (3) After the grievance procedure has been completed, a foster parent or former foster parent has a right of access to the grievance record of grievances the foster parent filed.
- (f) **Contested grievances.** Contested grievances are processed in accordance with OAC 340:2-3-46 unless otherwise provided in this Section.
- 340:2-3-51. Grievances of residents of DDSD Facilities: Southern Oklahoma Resource Center (SORC), Northern Oklahoma Resource Center of Enid (NORCE), and the Greer Center Facility (Greer)**
- (a) **Application.** This Section describes processes relating to grievances of residents of Oklahoma Department of Human Services (OKDHS) operated facilities listed in Sections 1406 and 1414.1 of Title 10 of the Oklahoma Statutes, the "residents," who want to file a grievance. Section 1415.1 of Title 10 of the Oklahoma Statutes confers on OKDHS the responsibility for establishing an ombudsman program which includes a grievance system at each OKDHS operated facility for persons with developmental disabilities.
- (b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-45(b) apply to this Section unless the context clearly indicates otherwise.
- (c) **Notice of grievance rights.** Form ~~OCA-GR-3~~ 15GR006E, Notice of Grievance Rights - DDSD Clients (General), is given by the Developmental Disabilities Services Division (DDSD) facility to a resident and his or her guardian within 24 hours of the resident's admission to a facility and yearly thereafter at the annual individual planning meeting. This form is used to identify the local grievance coordinator (LGC) and to explain the resident's right to grieve. After the resident or guardian signs the form, a copy is given to the resident or to the resident's guardian, or close family member if the resident does not have a guardian, or both, and the original is maintained in the permanent record for the resident.
- (d) **Filing and processing of grievance at the facility.** Grievances of residents are processed in accordance with OAC 340:2-3-45(g) unless otherwise provided in this Section.
- (1) The Office of Client Advocacy (OCA) maintains an ombuds office on campus at SORC and NORCE. OCA assigns advocates to its ombuds offices at the facilities who serve as the LGC at those facilities and Greer and provides assistance to residents, their guardians, and persons interested in their welfare who want to file a grievance. [OAC 340:2-3-71(h)(4)]
- (2) The OCA advocates at a facility send a copy of a grievance to the guardian or guardian ad litem of the resident and to the parent, unless contraindicated.
- (3) If a grievance involves a decision of a resident's team, the first level respondent is the applicable unit coordinator, unless the unit coordinator is involved in the decision being grieved.
- (e) **Time limits on filing grievances.** The time limit in OAC 340:2-3-45(g) does not apply to grievances filed by or on behalf of residents.
- (f) **Second level problem resolution.** The facility director is the second level respondent.
- (g) **Contested grievances.** When a resident asks to contest the administrator's response to a grievance, the contested grievance is processed in accordance with OAC 340:2-3-46.

The DDS director or designee is the state office administrator responsible for responding to contested grievances of residents.

(h) **Request for review by Grievance and Review Committee (GARC).** When a resident requests review by GARC of the DDS director's response to a grievance, the OCA grievance ~~coordinator~~ liaison prepares a request for GARC review using a format prescribed by OCA which includes the information listed in subsection (i) of this Section.

(i) **Advocate inquiry.** An OCA advocate may file a formal inquiry to request information relating to: the treatment of one or more residents; the substance, application, or interpretation of any policy, rule or regulation, written or unwritten, of OKDHS or an agent or contractor of OKDHS; or any decision, behavior, or action of an OKDHS employee, agent, or contractor, or of another resident.

(1) An advocate formal inquiry is submitted directly to the facility director or any other OKDHS employee believed to have the knowledge to respond to the inquiry. The person to whom the inquiry is submitted has seven business days from receipt of the inquiry to respond in writing. The advocate general can grant an extension.

(2) If the response does not resolve the concern which prompted the formal inquiry, or if a response is not timely received, the matter may be treated as a formal grievance and processed as a contested grievance pursuant to OAC 340:2-3-46.

(3) The advocate general issues a report that sets forth the subject matter of the inquiry, the pertinent facts, and recommendations. An advocate general report is submitted to the administrator, when applicable, and the state office administrator. A copy is submitted to the OKDHS Director.

(j) **Advocate grievance.** An OCA advocate can file a grievance on behalf of a resident even when a grievance has not been filed by or on behalf of a resident.

(1) At the discretion of the advocate general or designee, an advocate grievance is filed directly with the facility director. The facility director has seven business days to respond in writing. The advocate general can grant an extension for the facility director's response.

(2) If the facility director's response is not acceptable or is not timely submitted, it is processed as a contested grievance pursuant to OAC 340:2-3-46.

(k) **Fast track grievances.** When the subject of an OKDHS grievance is such that time is of the essence, with the approval of the advocate general or designee a grievance can be submitted directly to the facility director or to the OCA grievance ~~coordinator~~ liaison for processing as a contested grievance in accordance with OAC 340:2-3-46. When a grievance involves a time sensitive problem, the OCA grievance ~~coordinator~~ liaison can shorten the time for responding as warranted by the circumstances.

340:2-3-52. Grievances of Hissom class members

(a) **Application.** This Section describes processes relating to grievances of Hissom class members. The Oklahoma Department of Human Services (OKDHS) legal basis and authority for grievance policies and procedures for Hissom class

members includes orders of the United States District Court for the Northern District of Oklahoma in Homeward Bound, et al., vs. The Hissom Memorial Center, Case No. 85-C-437-E.

(b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-46(b) apply to this Section unless the context clearly indicates otherwise.

(c) **Notice of grievance rights.** The Office of Client Advocacy (OCA) advocate assigned to a Hissom class member gives Form ~~OCA-GR-3-A 15GR007E~~, Notice of Grievance Rights - Hissom Class Members, at least yearly to each class member or his or her guardian(s), close family members, and volunteer advocates. This form is used to identify the OCA advocate assigned to the class member and to explain the class member's right to grieve. After the class member, guardian(s), or both, sign the form, the advocate documents this in a contact sheet and provides copies to the client or the client's guardian, the assigned Developmental Disabilities Services Division (DDSD) case manager, and the program coordinator of the applicable provider for placement in the client's home record. The original is maintained in OCA's record for the class member.

(d) **Filing and processing of grievances.** Grievances of class members are processed in accordance with OAC 340:2-3-45 unless otherwise provided in this Section.

(1) OCA assigns an advocate to represent each class member. The assigned advocate serves as the grievance advisor for the class member and provides assistance to class members and persons interested in their welfare who want to file a provider or OKDHS grievance. [OAC 340:2-3-71(h)(4)] When an advocate files a provider or OKDHS grievance on behalf of a class member, the advocate contemporaneously provides a copy of the grievance to the DDS case manager assigned to the class member and to the DDS programs administrator for community services.

(2) Class members, their guardians, volunteer advocates and other advocates, case managers, personal support team members, and persons interested in their welfare also can file an OKDHS grievance by submitting Form ~~OCA-GR-1 15GR001E~~, Grievance Form, to the local grievance coordinator (LGC) in the appropriate DDS area office. When the LGC receives a grievance that has not been submitted by the OCA advocate representing the class member, the LGC promptly informs the advocate of the grievance by e-mail, fax, or telephone.

(3) If a grievance involves a decision of a class member's team, the first level respondent is the supervisor of the client's DDS case manager, unless the case manager is involved in the decision being grieved.

(e) **Provider grievances.**

(1) Each residential and vocational provider that contracts with DDS to provide services to Hissom class members has a grievance system for resolution of grievances. The provider's written grievance policies, forms, and procedures are in compliance with OAC 340:2-3-45.

(2) Provider grievances are initiated by the class member, the assigned OCA advocate, or a person interested in the welfare of the class member by using

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Form ~~OCA-GR-1~~ 15GR001E or the provider's grievance form. The completed grievance form is submitted to the provider's grievance coordinator. Upon receipt of a provider grievance by or on behalf of a Hissom class member by anyone other than the OCA advocate or the DDS case manager for the class member, the LGC promptly informs the DDS case manager and the advocate assigned to the class member by e-mail, fax, or phone. If an OKDHS employee initiates a grievance on behalf of a class member, at the time the grievance is filed the employee sends a copy to the DDS case manager and the OCA advocate assigned to the class member.

(3) If the subject matter of a grievance can be submitted for resolution as a provider grievance or an OKDHS grievance, the class member has the option to file it as a provider grievance, an OKDHS grievance, or both.

(f) **Time limits on filing grievances.** The time limit in OAC 340:2-3-45(g) does not apply to grievances filed by or on behalf of Hissom class members.

(g) **Fast track grievances.** When the subject of an OKDHS grievance is such that time is of the essence, with the approval of the advocate general or designee a grievance can be submitted directly to the OCA grievance ~~coordinator~~ liaison for processing as a contested grievance in accordance with OAC 340:2-3-46. When a grievance involves a time sensitive problem, the OCA grievance ~~coordinator~~ liaison can shorten the time for responding as warranted by the circumstances.

(h) **Second level problem resolution.** The area manager of the appropriate DDS area office is the individual responsible for responding to an OKDHS grievance at the second level of problem resolution.

(i) **Contested grievances.** When the response to an OKDHS or provider grievance is contested by a class member or a grievant on behalf of a class member, the contested grievance is processed in accordance with OAC 340:2-3-46 unless otherwise provided in this Section. The director of DDS is the state office administrator responsible for responding to contested grievances of class members.

(j) **Request for review by the Grievance and Abuse Review Committee (GARC).** When a Hissom class member requests review by GARC of the DDS director's response to a grievance, the OCA grievance ~~coordinator~~ liaison prepares a request for GARC review using the format prescribed by OCA that includes the information listed in subsection (i) of this Section.

(k) **Formal inquiry.** The advocate general or any OCA advocate staff may file a formal inquiry to request information relating to: the treatment of a client; the substance or application of any policy, rule, or regulation, written or unwritten, of OKDHS or an agent or contractor of OKDHS; or any decision, behavior or action of an OKDHS employee, agent or contractor, or of another client.

(1) A formal inquiry is submitted directly to the administrator of a community services provider or the appropriate DDS area manager. An advocate general formal inquiry is submitted to the director of DDS. The person to whom it is submitted has seven business days

to respond in writing. The advocate general can grant an extension.

(2) If the response to the formal inquiry does not resolve the concern that prompted the formal inquiry, the matter may be treated as a formal grievance and processed as a contested grievance.

(3) The advocate general issues a report that sets forth the subject matter of the inquiry, the pertinent facts, and recommendations. An advocate general report is submitted to the administrator, when applicable, and the state office administrator. A copy is submitted to the OKDHS Director.

(l) **Advocate grievances.** An OCA advocate may file a grievance on behalf of a class member even though a grievance has not been filed by or on behalf of the class member.

(1) At the discretion of the advocate general or designee, an advocate grievance is submitted directly to the administrator of a provider agency or the appropriate DDS area manager using Form ~~OCA-GR-1~~ 15GR003E, Grievance - Hissom Class Member.

(2) An advocate general grievance is submitted directly to the director of DDS or the administrator of the provider agency, whichever is applicable.

(3) The person to whom it is submitted has seven business days to respond in writing. The advocate general can grant an extension.

(4) If the response to a grievance is not acceptable, or is not timely submitted, it is processed as a contested grievance pursuant to OAC 340:2-3-46.

(m) **Monitoring of grievance programs.** Providers submit their policies for review and approval by the advocate general. OCA provides training and technical assistance to providers, at their request, in the development of grievance forms and procedures. OCA, in cooperation with other monitoring entities to avoid unnecessary duplication, monitors provider grievance programs in accordance with OAC 340:2-3-45(d) through (h).

340:2-3-53. Grievances of clients receiving services from the Developmental Disabilities Services Division (DDS)

(a) **Application.** This Section describes processes relating to grievances of clients receiving services from the Developmental Disabilities Services Division (DDS) who are not residing in an Oklahoma Department of Human Services (OKDHS) operated facility and are not Hissom class members. This Section includes minors and adults in specialized foster care.

(b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-45(b) apply to this Section unless the context clearly indicates otherwise.

(c) **Notice of grievance rights.** The DDS case manager gives Form ~~OCA-GR-3~~ 15GR006E, Notice of Grievance Rights - DDS Clients (General), to the service recipient, or guardian if applicable, at the initial plan of care meeting and at each annual plan of care meeting thereafter. If the service recipient does not have a DDS case manager, the provider gives Form ~~OCA-GR-3~~ 15GR006E to the service recipient within 30 calendar days of service initiation and annually

thereafter. Form ~~OCA-GR-3~~ 15GR006E is used to identify the local grievance coordinator and to explain the client's right to grieve. After the client or guardian signs the form, the original is maintained in the permanent record for the client.

(d) **Filing and processing of grievance.** Provider and OKDHS grievances are filed and processed in accordance with OAC 340:2-3-45. If a grievance involves a decision of an individual's team, the first level respondent is the supervisor of the client's case manager unless the case manager participated in making or approved the decision being grieved.

(e) **Time limits on filing grievances.** The time limit in OAC 340:2-3-45(g) does not apply to grievances filed by or on behalf of these clients.

(f) **Contested grievances.** When a grievant asks to appeal an OKDHS grievance, the appeal is processed in accordance with OAC 340:2-3-46.

(g) **Monitoring grievance programs.** OCA, in cooperation with other monitoring entities to avoid unnecessary duplication, monitors provider grievance programs in accordance with OAC 340:2-3-45(d) through (m).

340:2-3-55. Grievances of OKDHS clients not covered by another grievance system

(a) **Application.** This Section describes the grievance policy for persons receiving Oklahoma Department of Human Services (OKDHS) services not covered by another grievance system or issues not specifically addressed by OKDHS fair hearing process. A grievance or complaint is not processed under this Section if OKDHS has a formal administrative appeal or review process in place which addresses the grievance or complaint.

(b) **Definitions.** The definitions in OAC 340:2-3-2 and 340:2-3-45(b) apply to this Section unless the context clearly indicates otherwise.

(c) **Notice of client bill of rights.** The OKDHS Client Bill of Rights poster, OKDHS Pub. No. 92-06, is posted in conspicuous view of the public in all OKDHS offices and facilities. Applicants and recipients of benefits and services administered by OKDHS have the right to:

- (1) be treated with courtesy and dignity;
- (2) receive prompt service;
- (3) receive clear explanations of the laws and rules which determine eligibility for benefits and services;
- (4) have benefits and services explained in native language, if not able to understand English;
- (5) have benefits and services explained by an interpreter for the deaf, if unable to hear well;
- (6) have forms read and explained, if unable to read forms because of limited eyesight, or other inability to read;
- (7) receive fair and consistent consideration of any application for benefits or services;
- (8) have the opportunity for an appeal and a fair hearing in case of denial or reduction of benefits or services;
- (9) discuss with a local OKDHS supervisor any complaint regarding OKDHS benefits or services or treatment by OKDHS staff;

(10) contact the OKDHS Office of Client Advocacy (OCA) at 1-800-522-8014, regarding any complaint that has been discussed with, but not resolved by, the local office supervisory staff; and

(11) receive, upon request, a further explanation of applicant or client rights.

(d) **Filing a grievance.** Recipients of benefits and services administered by OKDHS, and persons acting on behalf of recipients, have the right to talk with a local OKDHS supervisor if they have a complaint about the way they were treated by OKDHS staff. Supervisory staff promptly seek to resolve the matter with the client. Clients have the right to contact OCA, Attn. Grievance ~~Coordinator~~ Liaison, P.O. Box 25352, Oklahoma City, OK 73125 (1-405-525-4850 or 1-800-522-8014, fax 1-405-525-4855) regarding any complaint which has been discussed with, but not resolved by, the local office supervisory staff.

(e) **Allegations of discrimination.** If a grievance or complaint alleges discrimination based on sex, age, national origin, religion, color or disability, the client is referred to the OKDHS Office for Civil Rights for appropriate handling and resolution of the complaint. The local grievance coordinator immediately forwards the grievance to the OKDHS civil rights administrator and so informs the grievant.

(f) **Processing a grievance.** When a client contacts OCA for assistance in resolving a complaint, OCA contacts OKDHS supervisory staff who have the authority to resolve the grievance to request a response to the grievance within seven business days.

(1) The advocate general may grant an extension for good cause, such as an unusually complex matter.

(2) If a complete response is not timely received by OCA, the grievance may be considered unresolved and processed as a contested grievance.

(3) After receiving a response to the grievance, OCA contacts the grievant to inform the grievant of the proposed resolution and the right to contest the response to the grievance. If the grievant is not satisfied with the outcome and requests to appeal the decision, the grievance is processed as a contested grievance. If OCA does not obtain a reply from the grievant within ten business days of actual notice to the grievant of the proposed response, the grievance may be deemed resolved.

(g) **Contested grievances.** Contested grievances of clients are processed in accordance with OAC 340:2-3-46.

PART 7. GRIEVANCE AND ABUSE REVIEW COMMITTEE

340:2-3-64. Grievance and Abuse Review Committee (GARC) review of unresolved contested grievances

(a) **Application.** GARC reviews unresolved contested grievances when the advocate general receives a proper request for GARC review in accordance with OAC 340:2-3-46(k).

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(b) **The GARC worksheet.** If the grievance was filed by or on behalf of a Developmental Disabilities Services Division (DDSD) client who receives Office of Client Advocacy (OCA) ombuds services, including residents of the Southern Oklahoma Resource Center (SORC), the Northern Oklahoma Resource Center of Enid (NORCE), or the Greer Center Facility (Greer), the OCA advocate prepares a GARC worksheet using a format prescribed by OCA which includes:

- (1) the grievance number and the names of the resident, grievant, guardian, parent(s), case manager, and OCA advocate;
- (2) a summary of the grievance process, resolutions offered at each level and the decision makers' responses;
- (3) the applicable statutes, policies, and other authorities;
- (4) the resolution sought by the grievant;
- (5) relevant documentation;
- (6) the OCA advocacy position with regard to the subject of the grievance; and
- (7) a copy of Form ~~OCA-GR-1~~ 15GR001E, Grievance Form, and Form ~~OCA-GR-1-A~~ 15GR002E, Local Grievance ~~Coordinator's~~ Coordinator (LGC) Worksheet.

(c) **Scope of GARC review.** GARC conducts a *de novo* paper review of the grievance.

- (1) Within three business days of receiving a proper request for GARC review pursuant to OAC 340:2-3-46(k), the advocate general or designee informs the affected state office administrator and administrator of the date of the GARC meeting.
- (2) The grievant, administrators, state office administrators, and their designees may attend the GARC meeting to answer questions. If a grievance involves a Hissom class member, the OCA programs administrator for the community ombuds program also attends.
- (3) If the grievant wants to submit additional evidence not considered during the processing of the grievance, it is submitted to the advocate general contemporaneously with the request for GARC review. If the administrator or affected state office administrator wants to submit additional evidence not considered during the processing of the grievance, or when GARC review is the result of an untimely response in accordance with OAC 340:2-3-46(I), or for good cause shown, evidence can be submitted to the advocate general seven business days before the GARC meeting.
- (4) When additional information is needed in order for GARC to complete its review, GARC may continue its review of a grievance until its next meeting. GARC may request additional information from OCA, an administrator, or a state office administrator.

(d) **GARC report contents.** Within 15 business days of a GARC meeting to review an unresolved grievance, GARC prepares a report that includes:

- (1) the subject matter of the grievance and identifying information about the grievant, the administrator, and the state office administrator;

- (2) the procedural history of the grievance, identifying proposed resolutions and responses at each step in the grievance process prior to the GARC review;
- (3) the resolution sought by the grievant and the resolution proposed by the state office administrator;
- (4) GARC's recommended resolution of the grievance;
- (5) the facts on which GARC bases its recommendation;
- (6) the information GARC considered in making its recommendation; and
- (7) areas of concern identified by GARC during its review of the case regarding facility or OKDHS practices or procedures.

(e) **Distribution of GARC report.** The advocate general forwards GARC's report to the applicable local grievance coordinator (LGC). Within three business days of receipt of GARC's report, the LGC contacts the grievant to inform the grievant of GARC's recommended resolution, and determines if the grievant is satisfied with it.

- (1) If the grievant needs time to decide whether to accept the proposed resolution, the grievant has two business days within which to make a decision. If no decision is communicated to the LGC within two business days, the grievant is deemed to have accepted the proposed resolution.
- (2) If the grievant is satisfied, the LGC notifies the advocate general, and the advocate general then notifies interested parties. An affected state office administrator has three business days from receipt of this notification to submit to the advocate general a written request for review by the Oklahoma Department of Human Services (OKDHS) Director.
- (3) If the grievant is not satisfied with GARC's recommended resolution and desires to contest it, the LGC notifies the advocate general within four business days of receipt of the GARC report. The advocate general transmits the request and GARC's report for review by the OKDHS Director.

(f) **OKDHS Director's review of a GARC recommendation.** Upon receipt by the advocate general of a proper and timely written request for review by the OKDHS Director, pursuant subsection (e) of this Section, the advocate general or designee transmits the request and the GARC report to the OKDHS Director.

- (1) Within 15 business days of receipt of GARC's report, the OKDHS Director decides whether to:
 - (A) adopt GARC's recommended resolution;
 - (B) adopt GARC's recommendation with modifications;
 - (C) return the matter to GARC for further consideration; or
 - (D) direct another resolution of the grievance.
- (2) If the OKDHS Director does not respond within 15 business days, the grievance is deemed resolved in accordance with GARC's recommended resolution.
- (3) The advocate general notifies the grievant and other interested parties of the result of the OKDHS Director's review. The grievant is informed that this concludes the

grievant's administrative remedies. If the grievant is a minor, a copy of the grievance and related materials are forwarded to the Office of Juvenile Systems Oversight in the Oklahoma Commission for Children and Youth.

(g) **Monitoring of resolution.** If the final resolution of the grievance involves an action to be taken by an OKDHS employee at a future date, the advocate general or designee identifies the target date and monitors compliance with that deadline. In the event of non-compliance, the advocate general notifies the OKDHS Director in writing.

PART 9. OMBUDSMAN PROGRAMS

340:2-3-73. Advocacy services for former residents of the Northern Oklahoma Resource Center of Enid (NORCE), the Southern Oklahoma Resource Center (SORC), and the Greer Center Facility (Greer)

(a) **Application.** This Section describes advocacy services the Office of Client Advocacy (OCA) provides to former residents of SORC, NORCE, and Greer ("the facilities") for whom the facility director is the guardian ad litem (GAL). Oklahoma Department of Human Services (OKDHS) has conferred on OCA responsibilities for each of these individuals until the court relieves the facility director of GAL responsibilities. Ombudsman and advocacy services are provided to former residents of the facilities consistent with Section 71 of this Subchapter.

(b) **Representation.** A person eligible for OCA services pursuant to this Section is assigned to an OCA advocate to represent the client's interests when OCA has adequate staff resources to provide such services. An advocate is assigned 30 calendar days prior to the date identified to transition the client. Clients are provided choices with regard to the advocate assigned to represent them to the extent feasible, taking into consideration the geographic location of the client's residence and the caseloads of OCA advocates. Requests for a change in the advocate representing an individual are made to the advocate general or designee.

(c) **Team membership.** As a representative of a Developmental Disabilities Services Division (DDSD) client living in a community residential placement, an OCA advocate is a member of the client's personal support team. As a team member, the advocate receives from the client's DDSD case manager timely notice of all team meetings, including emergency team meetings. Within the team context, the advocate assists the client and represents the client's interests without relinquishing priority to client safety and rights.

(d) **Guardianship issues.** The OCA advocate ensures a client has a current guardianship assessment and attends guardianship assessment meetings. If a client has sufficient capacity to require no guardian or only a limited guardian, the advocate promotes the filing of a petition with the guardianship court to terminate the GAL appointment or limit it, as the case may be. If the current guardianship assessment for the client recommends a guardian, volunteer advocate, or both, the OCA advocate participates with the team in identifying persons who

might serve as guardian or advocate for the client. An advocate encourages the development of friends in the community who might become a guardian or advocate for the client. When a guardian is needed and a suitable guardian has been identified, the advocate promotes the filing of a petition with the guardianship court to terminate the GAL appointment and to appoint a guardian.

(e) **Advocacy and monitoring.** OCA advocates provide advocacy and monitoring to ensure compliance with policies, rules, and regulations applicable to the health, safety, and well-being of clients. In addition to the services described in Section 71(h) of this Subchapter, advocacy and monitoring activities on behalf of each client include:

- (1) verifying Form ~~DDS-34~~ 06CB034E, Residential Pre-Service Checklist, has been completed and everything on the checklist is in place prior to the resident moving out of the facility;
- (2) a home visit with the client within 30 calendar days of the client's discharge from the facility;
- (3) verifying Form ~~DDS-34~~ 06CB034E has been completed prior to any subsequent changes in residence, and making a home visit with the client within 30 calendar days after the client moves into a new residence;
- (4) a face-to-face visit with the client at least quarterly and more frequently as indicated, which includes:
 - (A) site visits to a client's residence at least twice a year, every five to seven months, at a time when the client is present in the home; and
 - (B) visits with the client outside the home setting at least twice a year, every five to seven months;
- (5) visits with the client at the request of the client, the client's legal guardian, or other person concerned about the well-being of the client;
- (6) completion of a service review twice a year, every five to seven months;
- (7) in connection with each service review, verifying that direct contact staff have completed required training;
- (8) participating as a member of a resident's personal support team;
- (9) attending annual individual plan (IP) meetings, interim meetings, and follow-up planning meetings;
- (10) attending emergency team meetings;
- (11) attending other team meetings when significant issues are being addressed, including when a rights restriction or an intrusive behavior intervention strategy is contemplated or to be recommended;
- (12) attending guardianship assessment meetings of the client's team;
- (13) attending other team meetings at the request of the client, guardian, or involved family or friend;
- (14) requesting DDSD Quality Assurance to conduct an administrative inquiry of suspected provider contract violations in accordance with OAC 340:100-3-27;
- (15) assisting the client and the client's guardian or representative with the review of proposed financial agreements and contracts between the client and the provider;
- (16) review of documents, including but not limited to: assessments, IP and interim IP documents; incident

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reports; Adult Protective Services (APS) and OCA investigation findings; and behavior data collection forms;

(17) attending Behavior Review Committee (BRC) and Human Rights Committee (HRC) meetings as required or indicated;

(18) attending Death Review meetings held pursuant to OAC 340:100-3-35;

(19) attending legal proceedings involving the client, including guardianship proceedings, as warranted by the circumstances;

(20) monitoring semi-annually the hot water in homes where anti-scald devices have been installed, using a thermometer to ensure the water at the faucet where the device is located does not exceed 114 degrees and does not exceed 120 degrees when a tank device is used; and

(21) at least twice a year, every five to seven months, verifying that appropriate records are kept with regard to an individual's personal finances.

340:2-3-74. Advocacy services for Hissom class members

(a) **Application.** This Section describes Office of Client Advocacy's (OCA's) advocacy services for Hissom class members who reside in Oklahoma. Advocacy services are provided to Hissom class members consistent with Section 71 of this Subchapter. Orders of the United States District Court for the Northern District of Oklahoma in *Homeward Bound et al. v. vs. The Hissom Memorial Center, et al.*, Case No. 85-C-437-E, require the Oklahoma Department of Human Services (OKDHS) and OCA to provide independent advocacy services to individuals certified by the court as members of the plaintiff class, known as Hissom class members. This includes but is not limited to:

(1) independently advocating for class members rights and interests regarding: their daily lives, proposed movements, medical and behavioral emergencies including hospitalizations, appropriate consents, their financial interests, and meetings held on their behalf;

(2) appealing disagreements with a class member's individual plan through OKDHS grievance procedures, Sections 45, 46, and 52 of this Subchapter; and

(3) referral to protection and advocacy agencies in Oklahoma to obtain legal counsel and legal advocacy services.

(b) **Assignment of advocate.** OCA assigns an advocate to each Hissom class member living in Oklahoma. Clients are provided choices with regard to the advocate assigned to represent them to the extent feasible, taking into consideration the geographic location of the client's residence and the caseloads of OCA advocates. Requests for a change in the advocate representing an individual are made to the advocate general or designee.

(c) **Team membership.** As a representative of a Hissom class member living in a community residential placement, an OCA advocate is a member of the client's personal support team. As a team member, the advocate receives from the client's Developmental Disability Services Division (DDSD) case manager timely notice of all team meetings, including

emergency team meetings. Within the team context, the advocate assists the client and represents the client's interests without relinquishing priority to client safety and rights.

(d) **Guardianship issues.** The OCA advocate ensures the client has a current guardianship assessment and attends guardianship assessment meetings. If a client with a full guardianship has sufficient capacity to require no guardian or only a limited guardian, the advocate promotes the filing of a petition with the guardianship court to limit or terminate the guardianship. If the current guardianship assessment of a client who does not have a guardian recommends a guardian, volunteer advocate, or both, the OCA advocate participates with the team in identifying persons who might serve as guardian or advocate for the client. This includes encouraging the development of friends in the community who might become a guardian or volunteer advocate for the client. The OCA advocate monitors the implementation of the recommendations in the guardianship assessment and advocates for their timely achievement. When a guardian is needed and a suitable guardian has been identified, the advocate promotes the filing of a petition with the guardianship court to appoint a guardian.

(e) **Advocacy and monitoring services for class members in residential community settings.** OCA advocates provide advocacy and monitoring to class members living in community residential settings, including group homes, to ensure compliance with policies, rules, and regulations applicable to the health, safety, and well-being of clients. In addition to the activities described in Section 71(h) of this Subchapter, advocacy and monitoring activities on behalf of each client include:

(1) verifying a Form ~~DDS-34~~ 06CB034E, Residential Pre-service Checklist, is completed prior to any change in residence, and making a home visit with the client within 30 calendar days after the client moves into a new residence;

(2) a face-to-face visit with the client at least quarterly and more frequently as indicated, including:

(A) site visits to a client's residence at least twice a year, every five to seven months, at a time when the client is at home; and

(B) visits with the client outside the home setting at least twice a year, every five to seven months;

(3) visits with the client at the request of the client, the client's legal guardian, or other person concerned about the well-being of the client;

(4) completion of a service review twice a year, every five to seven months;

(5) in connection with each service review, verifying that direct contact staff have completed required training;

(6) participating as a member of a resident's personal support team;

(7) attending annual individual plan (IP) meetings, interim meetings, and follow-up planning meetings;

(8) attending emergency team meetings;

(9) attending other team meetings when significant issues are addressed, including when a rights restriction or an intrusive behavior intervention strategy is contemplated or recommended;

- (10) attending guardianship assessment meetings of the client's team;
- (11) attending other team meetings at the request of the client, guardian, or involved family or friend;
- (12) requesting DDS Quality Assurance to conduct an administrative inquiry of suspected provider contract violations in accordance with OAC 340:100-3-27;
- (13) assisting the client and the client's guardian or representative with the review of proposed financial agreements and contracts between the client and the provider;
- (14) prior to and during a hospitalization, advocating for the provision of adequate staff to be present in the hospital with the client as circumstances warrant;
- (15) review of documents, including but not limited to: assessments, IP and interim IP documents; incident reports; behavior data collection forms; and Adult Protective Services (APS) and OCA investigation findings;
- (16) attending Behavior Review Committee (BRC) and provider and Human Rights Committee (HRC) meetings as required or indicated;
- (17) attending Death Reviews conducted in accordance with OAC 340:100-3-35;
- (18) communicating to the client, the client's guardian, and the client's family as appropriate the final finding of an OCA investigation in which the client was named as an alleged victim;
- (19) attending legal proceedings involving the client, including guardianship proceedings, as warranted by the circumstances;
- (20) monitoring semi-annually the hot water in homes where anti-scald devices have been installed, using a thermometer to ensure the water at the faucet where the device is located does not exceed 114 degrees, and does not exceed 120 degrees when a tank device is used;
- (21) at least twice a year, every five to seven months, verifying that appropriate records are being kept with regard to an individual's personal finances; and
- (22) annually provide each client or guardian a copy of Form ~~OCA-GR-3A~~ 15GR007E, Notice of Grievance Rights: Hissom Class Members.

(f) **Advocacy services for Hissom class members in a private intermediate care facility for the mentally retarded (ICF/MR).** Advocacy and monitoring services for class members who reside in a private ICF/MR in Oklahoma are contained in this subsection.

- (1) The assigned OCA advocate personally visits a client living in a private ICF/MR at least semi-annually, and more frequently as warranted.
- (2) The OCA advocate maintains a helping relationship with the client, assessing the realization of desired and targeted outcomes, and initiating change through referral or grievance as needed. During contacts with the client, the advocate inquires about individual satisfaction with current supports and provides information regarding options available to clients for community supports.
- (3) The OCA advocate annually contacts the guardian of the client if one has been appointed. The OCA advocate also contacts the guardian in response to an expression

by the client of dissatisfaction with the current residential arrangements. These contacts reaffirm the availability of service options to clients for support in community settings. Contacts with the guardian occur in person, by phone or by mail as the circumstances warrant.

(4) The OCA advocate contacts the private ICF/MR case manager, generally a Qualified Mental Retardation Professional, responsible for yearly care planning for the client. The advocate informs the facility case manager of the advocate's intent to attend yearly planning meetings. The advocate asks to be notified in advance of yearly planning meetings and emergency meetings. The advocate checks periodically to ensure meetings have not been held without notice to the advocate.

(5) The OCA advocate participates in annual planning meetings at the private ICF/MR. The advocate provides advocacy assistance regarding expressed desires of the individual. The advocate brings to the attention of the care team concerns expressed by the client or guardian. The advocate participates in interim meetings addressing any significant change in residence, work, health, or important relationships.

(6) The OCA advocate develops a working knowledge of the facility's grievance procedure as well as other problem resolution processes and resources for change, for example, the Long-Term Care Ombudsman Program and licensing agencies. The advocate uses these services, either directly or through referral, as needed for the benefit of the individual.

(7) The OCA advocate assesses the welfare of the client and determines if advocacy assistance is needed which OCA can provide. The advocate provides assistance, either directly or through referral, with resolving concerns identified by the client or by others on behalf of the client. This includes contacting the OKDHS Aging Services Division, long-term care ombudsman. The advocate also informs the Long-Term Care Ombudsman Office of concerns involving non-clients living in an ICF/MR which come to the attention of the OCA advocate.

(8) Service reviews are not completed.

(9) The ICF/MR case manager is responsible for needed assessments, including the guardianship assessment. The DDS case manager can assist during the guardianship assessment. The OCA advocate requests a guardianship assessment on behalf of the client when there has been a substantial change in circumstances regarding the individual's need for a guardian.

(10) The OCA advocate provides information and encouragement to consider community residential settings.

(g) **Advocacy services for Hissom class members who are in custody.** Advocacy and monitoring services for class members who are in custody of the Department of Corrections or a county sheriff, except those who are detained pre-trial in a facility, are contained in this subsection. The assigned OCA advocate contacts the client at least semi-annually. The advocate assesses the welfare of the client and determines if advocacy assistance is needed that the advocate can provide. The advocate provides assistance, either directly or through

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referral, with resolving concerns identified by the client or by others on behalf of the client. Advocacy assistance is provided with regard to enforcing the rights of clients under the Americans with Disabilities Act and other state and federal laws to the extent they are applicable to persons who are in custody. When the client has less than a year remaining to serve in custody, the OCA advocate provides advocacy assistance with the DDS case manager to commence transition planning. The advocate participates in and monitors transition planning, representing the client's interests.

(h) **Services for Hissom class members who decline DDS services.** Pursuant to OAC 340:100-3-11, class members and their legal representatives have the right to refuse services from OKDHS. The OCA advocate for a class member who has declined DDS services, contacts the individual periodically and remains available to assist with advocacy regarding non-specialized assistance when desired by the individual.

[OAR Docket #07-558; filed 3-28-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 2. ADMINISTRATIVE COMPONENTS

[OAR Docket #07-559]

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PERMANENT final adoption

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Subchapter 31. ~~Planning, Legislative Relations and Policy, And Research~~

Part 4. ~~Planning And Research~~ Office of Legislative Relations and Policy
340:2-31-10 [AMENDED]

Part 5. Petitioning for Rulemaking

340:2-31-31 through 340:2-31-33 [AMENDED]

Subchapter 33. Rates and Standards

340:2-33-1 through 340:2-33-3 [AMENDED]

340:2-33-4 through 340:2-33-5 [REVOKED]

(Reference APA WF 06-21)

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Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; and Sections 250 et seq. of Title 75 of the Oklahoma Statutes.

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ANALYSIS:

Chapter 2, Subchapters 31 and 33, rule revisions: (1) remove language regarding planning and research due to organizational restructuring; (2) reflect the new name and responsibilities of the Office of Legislative Relations and Policy (OLRP); (3) update language regarding petitions for rulemaking; (4) reflect the current title of the Oklahoma Department of Human Services (OKDHS) and the Committee on Rates and Standards; and (5) revoke language that is internal OKDHS procedures.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 31. PLANNING, LEGISLATIVE RELATIONS AND POLICY, AND RESEARCH

PART 4. PLANNING AND RESEARCH OFFICE OF LEGISLATIVE RELATIONS AND POLICY

340:2-31-10. Planning, Policy, and Research (OPPR) Legislative relations and policy

(a) **Purpose.** ~~The purpose of the OPPR is to~~ Office of Legislative Relations and Policy (OLRP):

(1) ~~promote the growth and development of strategic planning~~ serve as the liaison between the Oklahoma Department of Human Services (OKDHS) and the state legislature;

(2) ~~serves as the liaison to the Oklahoma Health Care Authority (OHCA);~~

(3) ~~chairs and staffs the OKDHS Committee on Rates and Standards;~~

(4) ~~provides staff for the Human Services Cabinet;~~

(2) ~~encourage and support data driven decision making;~~

(35) ~~manage~~ Agency manages ~~OKDHS rules, policy, and procedures; and~~

(46) ~~ensure policies~~ ensures policy and other forms of communications comply with federal and state statutes;

(5) ~~provide technical support regarding research and statistical analysis;~~

(6) ~~support optimization of federal and other resources related to DHS' mission;~~

(7) ~~foster the development of highly productive internal processes that complement digital technologies;~~

(8) ~~assess whether policies and practices are attaining desired results or outcomes; and~~

(9) ~~assist in re-engineering policies and other forms of communications as needed to attain desired results or outcomes.~~

- (b) **Enabling legislation Legal authority.** Enabling legislation is described in (1) – (5) of this subsection:
- (1) ~~Enabling legislation for the Social Services Block Grant (SSBG) is Title XX of the federal Social Security Act.~~
 - (2) ~~Agency administrative OKDHS rules are promulgated as per the Administrative Procedures Act, Sections 250.1 – through 323 of Title 75 of the Oklahoma Statutes.~~
 - (3) ~~Agency annual report is produced and disseminated as per Section 162(a) of Title 56 of the Oklahoma Statutes.~~
 - (4) ~~Agency strategic plan is developed as per Section 45.3(A) of Title 62 of the Oklahoma Statutes.~~
- (c) **~~Social Services Block Grant (SSBG).~~** The ~~Social Services Block Grant Report of Intended Expenditures~~ for each federal fiscal year is submitted to the U.S. Department of Health and Human Services (DHHS) on or before September 30th of each year. ~~The SSBG Report of Actual Expenditures is submitted on or before March 31st following the end of the current federal fiscal year. A notice of submittal of both of these reports is published in the Journal Record newspaper.~~
- (d) **Annual Report.** The DHS Annual Report is submitted each year to the Governor of Oklahoma on or before November 1st.
- (e) **DHS Strategic Plan.** OPRR coordinates the review of the DHS Strategic Plan, described in OAC 340:1-1-18, as needed but no later than every five years. Strategies toward attaining the goals of the DHS Strategic Plan are updated and published annually via the DHS business plan.

PART 5. PETITIONING FOR RULEMAKING

340:2-31-31. Submission of petitions ~~Petitions for the promulgation, amendment or repeal of rules rulemaking~~

- (a) **Submission.** Any person may petition the Oklahoma Department of Human Services (OKDHS) in writing to request the promulgation, amendment, or repeal of a rule.
- (1) ~~Petitions must be~~ The petition for rulemaking is submitted to the OKDHS Office, of Planning, Legislative Relations and Policy (OLRP), and Research (OPPR), Policy Management Unit (PMU), Department of Human Services, by:
 - (A) mail to P.O. Box 25352, Oklahoma City, OK 73125, Attention, Policy Management Unit; or
 - (B) by delivery to the Sequoyah Memorial Office Building, 2400 North N. Lincoln Blvd., Oklahoma City, OK. ~~Petitions are~~
 - (2) The petition is considered submitted upon receipt in the Office of Planning, Policy, and Research OLRP.
 - (A) OLRP date stamps the petition for rulemaking to document date of receipt.
 - (B) Petitions A petition for rulemaking submitted to the OKDHS Director are is forwarded to, and considered submitted when received in, OPRR OLRP. Each petition is date stamped upon receipt in OPRR to show the date of submission.

- (b) **Form and content.** ~~A~~ The petition for rulemaking must be submitted as outlined in paragraphs (1) – (5) of this subsection. contain:
- (1) ~~The petition must contain~~ a clear statement of the action requested and the relief or solution desired as a result of the requested new rule or rule change, revision;
 - (2) ~~When the petition seeks to amend or repeal an existing rule, the existing rule must be identified. The~~ Title, Chapter, Subchapter, and Section, must be listed, if known, of the existing rule that is proposed to be revised or a copy of the rule submitted;
 - (3) ~~The petition must contain~~ a statement of the facts supporting the requested new rule or rule change, revision, including any legal grounds, and other relevant information or views on which the petitioner relies.
 - (A) A copy of any reference or source cited in the statement ~~must be~~ is submitted with the petition unless the reference or source is readily available to ~~the Department OKDHS.~~
 - (B) When a petition requests more than one rule change, revision, a single statement which that supports and justifies each proposed change, revision meets the requirements of this subsection;
 - (4) ~~The petition must describe~~ a description of the class or classes of persons, if known, who most likely will be affected by the proposed change, revision; and
 - (5) ~~The~~ the signature and printed name, address, and day time telephone number of the petitioner or his or her authorized representative must print his or her name, address, and day time telephone number on the petition and sign it.
- (c) **Incomplete or revised petition.**
- (1) When the petition for rulemaking does not contain minimally required information, the petitioner is sent a request for additional information in writing that specifies the manner in which the petition is deficient.
 - (2) The petitioner may supplement or revise the petition for rulemaking at any time prior to approval by the OKDHS Director or submission of the proposed change to the Oklahoma Commission for Human Services. Significant changes may result in re-initiation of the rulemaking process.

340:2-31-32. Consideration and disposition of petitions ~~petition for rulemaking~~

- (a) **Review of petition.** Within 15 calendar days after submission receipt of the a petition to promulgate, amend, or repeal a rule, the Office of Planning, Legislative Relations and Policy (OLRP), and Research reviews the petition and after consultation with the Oklahoma Department of Human Services (OKDHS) Director denies, requests additional information, or initiates the Department's rulemaking proceedings.
- (b) **Denial of petition.** The petition for rulemaking is denied, in whole or in part, on any of the grounds listed in (A) – (E) of this paragraph. when the petition:
- (A) ~~The~~ petition requests promulgation of a rule that the Department OKDHS is clearly without authority to promulgate;

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(B2) ~~The petition requests a new rule or rule change revision inconsistent with or that violates any applicable statutory or constitutional authority;~~

(C3) ~~The petition requests promulgation, amendment, or repeal of a Department an OKDHS policy that does not constitute a rule as defined in the Oklahoma Administrative Procedures Act, [75 O.S. at Section 250.3(2)] of Title 75 of the Oklahoma Statutes;~~

(D4) ~~The petition is frivolous and not being pursued proposed in good faith;~~ or

(E5) ~~The request for proposes a new or amended rules in the petition revised rule that is not feasible based on available and anticipated Agency OKDHS resources.~~

(iA) When denial is based on feasibility, the ~~administrator of OPPR~~ OLRP coordinator or designee, notifies the petitioner of the denial in accordance with OAC 340:2-31-33. The petitioner may make a written request to the ~~administrator of OPPR that OLRP coordinator to present~~ the petition ~~be presented to the Oklahoma Commission for Human Services (Commission).~~

(i) Within five working days of receipt of the request, the ~~OPPR administrator~~ OLRP coordinator submits the petition, written recommendations, and all other relevant information to the Chair of the Commission for ~~Human Services~~ with a copy to the affected division.

(ii) The Chair ~~for of~~ of the Commission of ~~Human Services~~ approves or denies the petitioner's request.

(I) If the Chair denies the petitioner's request, the ~~OPPR administrator~~ OLRP coordinator or designee notifies the petitioner in accordance with OAC 340:2-31-33 and the affected division.

(II) If the Chair approves the petitioner's request ~~is approved~~, the petition is placed on the Commission agenda and OLRP notifies the affected division notified.

(iii) At the Commission meeting, the petitioner may present ~~the~~ arguments in favor of the new rule or rule change revision. The ~~OPPR administrator~~ OLRP coordinator has the opportunity to present the Agency's OKDHS reasons for denial of the petition.

(iv) The Commission either directs the initiation of ~~the Department's~~ rulemaking procedures as requested, in full or in part, or denies the petition. The ~~OPPR administrator~~, OLRP coordinator or designee, notifies the petitioner in writing of the final Commission decision.

(2) ~~Additional information is requested from the petitioner, if the petition does not contain minimally required information. A request for additional information will be in writing and specify the manner in which the petition is deficient.~~

(3) ~~The Department's rulemaking proceedings are initiated by submitting the petition to the appropriate division administrator for action. A petitioner may supplement or revise a petition at any time prior to approval by the Director or submission of the proposed change to the Commission. However, significant changes may result in reinstitution of the rulemaking process. The Department's rulemaking proceedings shall be undertaken according to the schedule provided in (A) (C) of this paragraph.~~

(c) Approval of petition. OKDHS rulemaking proceedings are initiated when OLRP submits the approved petition for rulemaking to the appropriate division director for action.

(A1) Within 60 calendar days after submission receipt of the petition by the affected division, the division ~~administrator~~ director places the proposed new rule or rule change revision into the proper format for ~~the Department's codified rules proposed rulemaking action~~, and circulates submits the proposal to OLRP for intra-agency circulation and review.

(B2) Intra-agency review ~~will be is~~ completed and the proposed new rule or rule change revision is submitted to the OKDHS Director within 45 calendar days after initial intra-agency circulation.

(C3) Within 30 calendar days of receipt of the proposed new rule or rule revision by the OKDHS Director, the OKDHS Director recommends approval, disapproval, or amendment of the proposed rule change. ~~If When~~ the Director recommends approval, the ~~OPPR administrator~~, OLRP coordinator or designee, submits the proposal to the Commission for action at the next regularly scheduled Commission meeting for which there has been sufficient time to place the proposal on the Commission agenda.

340:2-31-33. Notice Notification to petitioner

Within five working days of receipt of the petition for rulemaking, the ~~OPPR administrator~~ Office of Legislative Relations and Policy (OLRP) coordinator or designee ~~shall provide provides~~ written notification to the petitioner ~~that of receipt of the request has been received petition~~. Within five working days ~~of after~~ any action taken related to the petition, ~~OPPR shall also provide OLRP provides~~ written notification to the petitioner of:

(1) denial of ~~a the~~ petition, in whole or in part, including the reasons for the denial;

(2) initiation of ~~the Department's Oklahoma Department of Human Services (OKDHS) rulemaking proceedings~~, including the date of submission of the proposed rule change will be submitted revision to the OKDHS Director for approval;

(3) the substance of comments received and any revisions made during the intra-agency review period, ~~and include including~~ a copy of the proposed revised rule proposed by the division;

(4) any action by the OKDHS Director and the Commission for Human Services (Commission) on the proposed rule change or any revision of the proposed rule change; and

(5) the date, time, and place of the Commission meeting when the proposed rule change or any revision of the proposed rule change will be considered.

SUBCHAPTER 33. RATES AND STANDARDS

340:2-33-1. Purpose

(a) The purpose of this Subchapter is to describe the process that the Oklahoma Department of Human Services (OKDHS) uses for establishing and modifying fixed rates and service levels for service provider contracts.

(b) The Oklahoma Commission for Human Services (Commission) is the official rate setting body for the programs administered by the department OKDHS.

(c) The policies and procedures in this Subchapter describe how information and recommendations are collected and provided to the Commission members for their use in establishing service rates and standards for services.

340:2-33-2. Legal base basis and role of the Department of Central Services

(a) The legal base basis for establishing fixed and uniform rates is the Oklahoma Central Purchasing Act found at Section 85.1 et. seq. of Title 74 of the Oklahoma Statutes.

(b) The statute requires that any agency desiring to have a service qualified for a fixed and uniform rate, or an established rate modified, submit a written request and all supporting documentation to the Department of Central Services (DCS). If DCS qualifies such service for a fixed and uniform rate, the rate must then be approved in a public hearing before a contract can be legally entered into by the agency.

(1) The agency notifies the Director of DCS at least 30 days in advance of the scheduled hearing. Along with the notice the agency delivers a copy of the agenda items relating to the proposed rate with all supporting documentation.

(2) The Director of DCS communicates a recommendation to the agency either in advance of the hearing or at the time of the hearing. Whether made in person or in writing, any comment made by the Director of the DCS is, by law, included in the minutes of the hearing.

(c) Within two weeks after the convening of the Legislature, the administrative officer of each state agency furnishes to the Speaker of the House of Representatives and the President Pro Tempore of the Senate a complete list of all the types of services paid for by uniform fixed rates and the number of contracts in existence for each type of service.

340:2-33-3. ~~The Advisory Committee on Rates and Standards~~

(a) The ~~Advisory Committee on Rates and Standards~~ (Committee) is comprised of Oklahoma Department of Human Services (OKDHS) administrative and executive level staff designated by the OKDHS Director for ~~Human Services~~.

(b) The Oklahoma Commission for Human Services (Commission) is the official rate setting body for OKDHS.

(c) The ~~Advisory Committee on Rates and Standards~~ serves the rate setting process by conducting public hearings at which the public, vendors, and OKDHS staff are afforded the opportunity to provide testimony and documented evidence in support of rate recommendations.

(1) The Committee, by majority vote, records a recommendation to the Commission for ~~Human Services~~ setting forth specific rates of payment for specific services. If the Committee determines additional information is needed, the chair may recess the meeting until a later date to allow interested parties or staff additional time to secure the information.

(2) Once the Committee reaches a recommendation, the chair schedules the rate issue to be heard at the next scheduled ~~meeting of the Commission~~ meeting.

(3) At the Commission meeting, the Committee chair presents the rate issue and relays the Committee's recommendation to the Commission.

(4) After the presentation and after hearing further public testimony, if appropriate or requested, the Commission votes to approve, deny, or modify the recommendation of the ~~Committee on Rates and Standards~~.

340:2-33-4. Responsibilities of the rate requesting division [REVOKED]

~~Responsibilities of the rate requesting division are to:~~

- ~~(1) research and gather documentation supporting a request for qualifying a service for fixed rates and establishing the initial rate or for modifying an established rate;~~
- ~~(2) submit the written request for rate action, together with supporting documentation and any policy revisions, to the chair of the Rates and Standards Committee and to the supervisor of Policy Management and Analysis;~~
- ~~(3) provide any additional information requested by the Committee on Rates and Standards or Policy Management and Analysis;~~
- ~~(4) invite stakeholders and other interested parties to attend, participate, or both, in the public hearing;~~
- ~~(5) present the proposed rate and supporting documentation at any meetings requested by the committee prior to the public hearing;~~
- ~~(6) present the proposed rate and supporting documentation at the public hearing; and~~
- ~~(7) ensure staff is available at the commission meeting to answer any questions commission members may pose concerning the rate proposal.~~

340:2-33-5. Policy Management and Analysis' responsibilities in the rate setting process [REVOKED]

~~The responsibilities of the Policy Management and Analysis Unit of the Office Support Services Division are to:~~

- ~~(1) maintain official record of rate setting activities;~~
- ~~(2) correspond with the Department of Central Services (DCS) by:~~
 - ~~(A) securing required information from the rate requesting division and submitting written requests to~~

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- ~~DCS requesting specified services be qualified for fixed rates or an established rate be modified;~~
~~(B) writing and submitting notifications of rate hearings including the agenda and supporting documentation for the recommended rate at least 30 days in advance of the hearing as required by law; and~~
~~(C) responding to questions or requests from DCS.~~
- (3) ~~route a copy of the public notice and the agenda to the Secretary of State for each public meeting;~~
(4) ~~fax a copy of the agenda and public notice to the Oklahoma Legislative Reporter;~~
(5) ~~schedule a pre-meeting of the Rates and Standards Committee members and the rate requesting division to review documentation and prepare for the formal public hearing; and~~
(6) ~~perform coordinating functions pertaining to the rate setting process by:~~
- ~~(A) preparing, circulating, and posting meeting agendas;~~
~~(B) reserving and preparing hearing and meeting rooms; and~~
~~(C) organizing information from the rate requesting division in the form of an issue paper to be mailed to Commission members in advance of the meeting scheduled for the Commission to hear the rate request.~~

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In Chapter 2 a new Subchapter and Section is created due to the Oklahoma Department of Human Services (OKDHS) reorganization establishing the Office of Planning, Research, and Statistics (OPRS). The new rule describes the purpose and responsibilities of OPRS.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 39. PLANNING, RESEARCH, AND STATISTICS

340:2-39-1. Planning, research, and statistics

(a) Purpose. The purpose of the Office of Planning, Research, and Statistics (OPRS) is to:

- (1) promote the growth and development of strategic planning;
- (2) encourage and support data-driven decision making;
- (3) provide technical support regarding research, statistical analysis, and grant proposals;
- (4) support optimization of federal, state, and other resources in support of the Oklahoma Department of Human Services (OKDHS) mission;
- (5) assess whether policies and practices are attaining desired results or outcomes; and
- (6) assist in re-engineering policies and other forms of communications as needed to attain desired results or outcomes.

(b) Reports. OPRS prepares and files reports for the:

- (1) Social Services Block Grant (SSBG), Title XX of the federal Social Security Act, which includes the:
 - (A) Report of Intended Expenditures for each federal fiscal year that is submitted to the U.S. Department of Health and Human Services (DHHS) on or before September 30 of each year, per Section 96.10 of Title 45 of the Code of Federal Regulations (45 CFR § 96.10);
 - (B) Report of Actual Expenditures for each federal fiscal year that is submitted to DHHS on or before March 31 of each year per 45 CFR § 96.74; and
 - (C) a notice of submittal for each report that is published on the OKDHS Internet on or before the respective submitted date;
- (2) OKDHS Annual Report, required by Section 162(f) of Title 56 of the Oklahoma Statutes (56 O.S. § 162(f)) that

is produced and submitted each year to the Governor on or before November 1; and
(3) OKDHS Strategic Plan, required by 62 O.S. § 45.3(A) that is produced and submitted every two years as described in OAC 340:1-1-18.

[OAR Docket #07-560; filed 3-28-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 5. ADULT PROTECTIVE SERVICES**

[OAR Docket #07-561]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

340:5-1-8 [AMENDED]

(Reference APA WF 06-15)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2, 3, and 4 of the Oklahoma Constitution; and Sections 10-101 through 10-110 of Title 43A of the Oklahoma Statutes.

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n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Adult Protective Services (APS) rule revisions change the responsibility of responding to complaints on APS policy and procedures and conducting a case review from the APS field liaison to the county director.

CONTACT PERSON:

Dena Thayer, Programs Manager, Policy Management Unit, OKDHS, 2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-3611.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 1, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

340:5-1-8. Complaints concerning the APS program

Complaints regarding an investigation or the provision of services may be submitted to the Oklahoma Department of Human Services (OKDHS) by telephone or in written form, including ~~email~~ e-mail. Complaints regarding:

- (1) ~~For complaints regarding the~~ Adult Protective Services (APS) policy and procedure are referred to the county director who performs, a case review ~~is performed by the area APS field liaison~~. A written response is provided to the complainant within 45 days stating the general findings of the review. ~~No confidential information is included in the letter. A copy of the letter is also sent to the Family Support Services Division (FSSD), APS Unit;~~
- (2) ~~Complaints regarding~~ possible inappropriate treatment by an APS specialist or supervisor are referred to the appropriate county director for appropriate action. ~~The FSSD, APS Unit is available to assist in any case reviews necessary to resolve the complaint; and~~
- (3) ~~Complaints regarding~~ involuntary services are handled through the appropriate judicial system. ~~The OKDHS Office of General Counsel may be consulted when these complaints are received.~~

[OAR Docket #07-561; filed 3-28-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 10. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)**

[OAR Docket #07-562]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 2. Temporary Assistance for Needy Families (TANF) Work Program

340:10-2-1 [AMENDED]

Subchapter 3. Conditions of Eligibility - Need

Part 3. Income

340:10-3-33 [AMENDED]

(Reference APA WF 06-08 and 06-11)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; Sections 230.50, 230.52, 230.55, 230.56, 230.60, and 230.62 through 230.66 of Title 56 of the Oklahoma Statutes; the Personal Responsibility and Work Opportunity Act of 1996; and the Deficit Reduction Act of 2005.

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Subchapter 2. Temporary Assistance for Needy Families (TANF) Work Program

340:10-2-1. [AMENDED]

(Reference APA WF 06-11)

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Superseded rules:

Subchapter 3. Conditions of Eligibility - Need

Part 3. Income

340:10-3-33. [AMENDED]

(Reference APA WF 06-08)

Gubernatorial approval:

August 24, 2006

Register publication:

24 Ok Reg 28

Docket number:

06-1277

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Temporary Assistance for Needy Families (TANF) rule revisions: (1) reflect an increase in the standard deduction for work related expenses for TANF applicants and recipients who are employed 30 or more hours per week; (2) denote work activities, work-eligible individuals, and calculation of work participation rates in the TANF Work program.

CONTACT PERSON:

Dena Thayer, Programs Manager, Policy Management Unit, OKDHS, 2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-3611.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 1, 2007:

SUBCHAPTER 2. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) WORK PROGRAM

340:10-2-1. Work requirements

All parents or needy caretakers who apply for or receive cash assistance from the State of Oklahoma are required to be engaged in a work activity. The parent(s) or needy caretaker must participate in work activities for the number of hours weekly that are necessary to move that individual into employment and self-sufficiency.

(1) **Work-eligible individual.** A work-eligible individual is defined as an adult or minor head-of-household included in the Temporary Assistance for Needy Families (TANF) assistance unit. Excluded from this definition is a parent providing care for a disabled family member living

in the home who does not attend school on a full-time basis, provided the need for such care is supported by medical documentation.

(+2) **Minimum hours of work activities.** Minimum hours of work activities for federal reporting purposes differ for single parent and two parent families.

(A) All families, which include single parents with children, both adults with deprivation based on incapacity, and all Temporary Assistance for Needy Families (TANF) applicants, and recipients who meet the definition of a work-eligible individual are required to participate the minimum hours of work activities:

(i) A work-eligible individual is required to participate an average of 30 hours per week, with the exception of a single custodial parent with a child under age six who must participate an average of 20 hours per week for Federal Fiscal Year (FFY) 1997 and 1998.

(ii) ~~25~~ In a two-parent family when deprivation is based on incapacity, the non-incapacitated adult must average 30 hours per week for FFY 1999; and, unless required in the home to provide care for the incapacitated work-eligible parent.

(iii) In a two-parent family when deprivation is based on unemployment, one adult must participate in work activities an average of 35 hours per week and the other adult must participate an average of 30 hours per week for FFY 2000 and thereafter. If one parent is an ineligible alien, the other parent must participate an average of 35 hours per week.

(B) ~~In two parent families one adult is required to be engaged in work activities at least 35 hours per week and the other adult must meet the all family requirement listed in subparagraph (A) of this paragraph. If one parent is an ineligible alien the other parent must participate 35 hours a week.~~

(B) Hours missed due to holidays and a maximum of an additional 80 hours of excused absences count as hours of participation for any unpaid scheduled work activity.

(i) Federal law establishes public holidays. State holidays are ordered observed by the Governor. Scheduled short-term closures by the facility the participant attends can be included as holidays. If the facility where the participant is scheduled to attend is open on a designated holiday, this day is not considered a holiday for participation purposes.

(ii) Excused absences are reasonable, short-term hours missed from a scheduled work activity. There are a maximum of 10 days or 80 hours of excused absences in any 12-month period. No more than two days or 16 hours of excused absences in a month are counted as hours of TANF Work participation. All excused absences must be approved by the worker. An excused absence is defined as:

- (I) unavailability of appropriate child care;
- (II) illness or injury of the participant or a family member who lives in the household. The family member must meet the definition of a relative per OAC 340:10-9-1;
- (III) scheduled doctor appointments for the participant or a family member who lives in the household;
- (IV) court-required appearance by the participant;
- (V) required attendance at parent and teacher conferences by the participant;
- (VI) temporary unavailability of planned transportation when needed or inability to arrange for transportation;
- (VII) occurrence of inclement weather that prevented the participant, and other persons similarly situated, from traveling to, or participating in, the prescribed activity;
- (VIII) crisis intervention needed due to domestic violence issues;
- (IX) family crisis; or
- (X) required attendance of the participant for a specific appointment by another governmental entity.

(iii) To count an excused absence or holiday as hours of participation, the individual must have been scheduled to participate in an allowable work activity for the period of the absence. Participation allowances are paid for approved holidays and approved excused absences.

(23) **Work activities.** Work activities are defined as, but are not limited to: core and non-core and must be scheduled, structured, and supervised. TANF Work participants are placed in core work activities when appropriate.

(A) Core work activities are:

- (A*i*) unsubsidized employment that is full-time or part-time employment in the public or private sector that is not subsidized by TANF or any other public program;
- (B*ii*) subsidized private sector employment that is employment in the private sector for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing a recipient;
- (C*iii*) subsidized public sector employment that is employment in the public sector for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing a recipient;
- (D*iv*) Work Experience Program (WEP) participation if sufficient private sector employment is not available that is a work activity that provides an individual with an opportunity to acquire general skills, training, knowledge, and work habits necessary to obtain employment;

- (E*v*) on-the-job training that is training in the public or private sector that a paid employee receives while he or she is engaged in productive work and that provides knowledge and skills essential to the full and adequate performance of the job;
- (F*vi*) job search that is the act of seeking or obtaining employment and job readiness that prepares the person to seek or obtain employment, and includes life skills training, substance abuse treatment, mental health treatment, or rehabilitation activities for those who are otherwise employable;
- (G*vii*) job readiness assistance community services that are structured programs in which TANF recipients perform work for the direct benefit of the community under the auspices of public or non-profit organizations; and
- (H*viii*) vocational training, not to exceed 12 months, with respect to any individual that are organized educational programs directly related to the preparation of individuals for employment in current or emerging occupations requiring training other than a baccalaureate or advanced degree.

(B) Non-core work activities are:

- (i) job skills training directly related to employment that is training or education for job skills required by an employer to provide an individual with the ability to obtain employment or to advance or adapt to the changing demands of the workplace;
- (ii) education directly related to employment, in the case of a recipient who has not received a high school equivalency, that is education related to a specific occupation, job, or job offer; and
- (iii) satisfactory school attendance at a secondary school or in a course of study leading to a General Educational Development (GED) certificate, in the case of a recipient who has not completed secondary school or received such a certificate, that is regular attendance with the requirements of the secondary school, or in a course of study leading to a GED certificate.

(34) **Limitations and special rules.** A single custodial parent who has:

- (A) who has not attained 20 years of age and has not completed high school is determined to be in a work activity for a the month if the recipient maintains satisfactory attendance at a secondary school or the equivalent during the month; or
- (B) with a child under the age of three four months is not required to participate in a work activity. The recipient can use this special rule for a lifetime period limit not to exceed 12 months.

SUBCHAPTER 3. CONDITIONS OF ELIGIBILITY - NEED

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PART 3. INCOME

340:10-3-33. Individual earned income exemptions

Exemptions from each individual's earned income include a monthly standard work related expense and one-half of the remaining earned income. Exemptions are also allowed for child and adult dependent care expenses the individual is responsible for paying if expenses are not paid through other state and federal funds and the dependent care is in a licensed facility or home. Exempt income is income which by law is not considered in determining need for financial assistance in the Temporary Assistance for Needy Families (TANF) category. Income exempt for one individual is not taken into consideration in determining the need of any other individual for assistance in the State Supplemental Payment (SSP) for the aged, blind, and disabled and TANF.

(1) **Work related expenses.** The standard deduction for work related expenses such as income tax payment, Social Security taxes, and transportation to and from work, is ~~\$120~~ automatically determined monthly for each full-time or part-time employed member of the assistance unit, ~~or~~.

(A) The standard deduction for work related expenses is:

(i) \$240 for a recipient employed a minimum of 30 hours per week;

(ii) \$120 for a recipient employed less than 30 hours per week; and

(iii) \$120 for an individual whose income is considered in determining the amount of the TANF cash assistance.

(B) The ~~\$120~~ standard deduction for work related expenses is not applied to earnings of participants in the Work Supplementation Program (WSP).

(2) **One-half remainder.** For all countable income earned by each member included in the assistance unit, as well as a stepparent who is not included in the assistance unit, one-half of the remaining earned income is exempted. [OAC 340:10-3-57(f)(1)] The one-half remainder exemption is not applied to earnings received by participants in ~~the~~ WSP. An applicant is only eligible for one-half of the remainder exemption ~~if~~ when:

(A) an individual in the TANF assistance unit was included in a TANF benefit in any of the 50 states in addition to the Virgin Islands, Puerto Rico, and Guam, during one of the four months preceding the application; or

(B) the total income of all members minus work related expenses and dependent care expenses is less than the TANF ~~Need Standard~~ need standard found on Oklahoma Department of Human Services (OKDHS) Appendix C-1, Maximum Income, Resource, and Payment Standards, for the appropriate number of ~~persons~~ individuals.

(3) **Dependent care expenses.** Dependent care ~~expense~~ expenses are applied after all other earned income exemptions.

(A) Dependent care expenses are not deducted from earnings of participants in ~~the~~ WSP. Dependent care ~~expense~~ expenses may be deducted when:

(i) suitable care for a child or incapacitated adult included in the TANF assistance unit is not available from responsible ~~persons~~ individuals living in the home or through other ~~alternate~~ sources;

(ii) the employed TANF assistance unit member whose income is considered in computing the amount of the benefit must purchase care;

(iii) the gross earned income equals or exceeds the work related and dependent care expenses combined;

(iv) the child or incapacitated adult receives care in a properly licensed facility or from an approved in-home provider as required by Oklahoma law; and

(v) the stepparent of the child(ren) for whom TANF is requested is living in the home and has dependents not included in the assistance unit who are also living in the home. [OAC 340:10-3-57(f)(1)]

(B) Dependent care expenses must be verified, ~~and~~ The actual amount paid per month is deducted up to a maximum of \$200 for a dependent under the age of two or \$175 for a dependent age two or older or for an incapacitated adult. In considering the dependent care expense, only actual work hours and travel time between work and the care facility is allowed. Payment for dependent care is the individual's responsibility. The individual must immediately report any changes in the plan of care.

(C) Dependent care provided by another ~~person~~ individual in the household who is not a member of the assistance unit may be considered as long as the caregiver meets applicable state, local, or tribal law.

[OAR Docket #07-562; filed 3-28-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 10. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

[OAR Docket #07-563]

RULEMAKING ACTION:

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RULES:

Subchapter 2. Temporary Assistance for Needy Families (TANF) Work Program

340:10-2-3 [AMENDED]

340:10-2-5 through 340:10-2-7 [AMENDED]

Subchapter 10. Conditions of Eligibility - Deprivation

340:10-10-4 [AMENDED]

340:10-10-6 [AMENDED]

(Reference APA WF 06-14)

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Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; Sections 230.50, 230.52, 230.55, 230.56, 230.60, and 230.62 through 230.66 of Title 56 of the Oklahoma Statutes; the Personal

Responsibility and Work Opportunity Act of 1996; and the Deficit Reduction Act of 2005.

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ANALYSIS:

Temporary Assistance for Needy Families (TANF) rule revisions: (1) add additional assessment tools to determine participant's interests and skills; (2) limit job search and job readiness activities; (3) reflect current form names and numbers; and (4) remove an obsolete rule.

CONTACT PERSON:

Dena Thayer, Programs Manager, Policy Management Unit, OKDHS, 2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-3611.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 1, 2007:

SUBCHAPTER 2. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) WORK PROGRAM

340:10-2-3. Employability planning

(a) **Scope and applicability.** The employability planning process begins at intake and continues as long as there are employment barriers or family circumstances which interfere with the participant obtaining and retaining employment. The worker and the participant initiate Form ~~TW-2~~ 08TW002E, TANF Work/Personal Responsibility Agreement. In the development of the employability plan, the worker takes into consideration the need for English as a ~~Second Language~~ second language, basic education, literacy, learning disabilities, counseling or treatment for substance abuse or mental health issues, and crisis intervention for domestic violence.

(1) Substance abuse screening is required for every new Temporary Assistance for Needy Families (TANF) participant.

(2) Literacy screening is required for individuals who have not obtained a high school diploma or General

Educational Development (GED) certificate and have demonstrated a lack of literacy skills.

(b) **Interest and ability assessments.** Assessments are required to determine the participant's skills, abilities, and barriers. Assessment tools used are the Washington State Learning Disability Screen, the Test of Adult Basic Education (TABE) locator, the TABE battery, ~~and~~ the Career Occupation Preference System (COPS), Key Train, and Career Readiness Certification. ~~These can be obtained through the statewide assessment contract or a community partner.~~

(1) The use of these assessments provides the worker, participant, assessment specialist, and/or community partners with:

- (A) an indication of possible learning disabilities;
- (B) a measurement of the participant's skills, abilities, interests, and aptitude; and
- (C) meaningful information to create a valid employability plan.

(2) Participants referred for testing are informed of the use that is made of the test results. Test scores are kept confidential but may be shared with community partners. Referrals for testing are made by use of Form ~~TW-3~~ 08TW003E, Interagency Referral and Information. Participants in formal assessments are eligible for participant allowances and child care.

(c) **Employability planning.** The worker and the participant use the information from the assessment and other relevant information to develop a plan for securing employment. The employability plan includes establishing both short and long term goals, including specific occupational goals, activities, and services which are necessary to achieve the goals.

(1) The employability plan may include staffing with other community partners for assignment to specific work activities, collaboration with other agencies for services such as job placement, training, and education, and the provision of social services. The plan must identify specific needs and activities required to reach the occupational goal and estimated dates for achievement. The plan may include more than one activity at a time based on the participant's specific needs and the hours available. The employability plan is a part of the social services plan for the entire family. It must be realistic and within the participant's ability to complete.

(2) The participant is informed that the employability plan is updated as necessary to account for situational changes. The employability plan is reviewed with the participant and updated as changes occur and at the completion of any work activity. If no changes have occurred, the worker reviews the employability plan within six months.

(3) Participants who are employed with income insufficient to close the case must have a plan designed to upgrade employment. These plans must not interfere with current employment.

(d) **Work activities.** Participants are assigned to one or more activities and scheduled the minimum number of hours as required. The participant signs Form ~~TW-2~~ 08TW002E, when

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any work activity other than the Work Experience Program or Work Supplementation Program is approved.

- (1) Assignments must be within the scope of the participant's employability plan.
- (2) The assignment must be related to the capability of the participant to perform the task on a regular basis.
- (3) The daily commuting time to and from home to the assigned education, employment, or training site is normally less than two hours. Commuting time does not include the time required to transport a child to and from a child care facility. Where longer travel time is normal in the community, the round trip commuting time may not exceed the general community standards.
- (4) When child care is required, it must be of the participant's choosing. It must be available during the hours the participant is engaged in any work activity, plus any additional commuting time.
- (5) Assignments which are discriminatory in terms of age, sex, race, religion, ethnic origin, or physical or mental disability are not made.
- (6) The site of the assignment must not be in violation of established and applicable health and safety standards.
- (7) The participant is not referred for a work activity unless supportive services necessary for participation are available. The cessation or withdrawal of such services constitutes good cause for refusal to participate.
- (8) When the agreed upon employability plan requires hours in excess of the minimum requirement, the participant must participate the agreed upon number of hours.

340:10-2-5. Job search activities

The primary objective of all job search activities is for applicants and recipients of Temporary Assistance for Needy Families (TANF) to obtain employment through personal contacts with employers. The ~~social services specialist worker~~ and the individual jointly determine the number of employer contacts based on availability of child care, financial resources, jobs in the community, skills and abilities, and any other factors which affect or influence the individual's ability to obtain employment.

- (1) An employer contact is defined as a face-to-face interview with an employer, the completion and return of any application to an employer, or the completion of tests required for employment with the state, local, or federal government. Referrals to employers are made on Form ~~TW-11~~ 08TW011E, Referral to Employment. The individual records employer contacts on Form ~~TW-10~~ 08TW010E, Employer Contact List.
- (2) Job search is defined as the individual's job seeking efforts. Individuals in job search activities are eligible for participant allowances and day care for the time they are actively looking for a job or in a group activity.

(A) The individual is given Form ~~TW-13~~ 08TW013E, TANF Time and Progress Report, to complete and return to the ~~social services specialist worker~~.

- (i) Additional job search may be required as a part of another work activity if it would improve

the individual's employment prospects. ~~The placement services of other agencies, such as Job Training Partnership Act, community colleges, and vocational technical schools, are used when available.~~

(ii) The number of employer contacts to be made each week is included in the employability plan. ~~The social services specialist makes a face to face contact with each individual to determine progress, to see if any problems exist, and to offer encouragement and support.~~

(B) If the individual has been unsuccessful in obtaining a job after a reasonable amount of time, the ~~social services specialist~~ worker and individual review the employability plan to determine if another activity is more appropriate.

(C) The maximum amount of time spent in job search and job readiness activities cannot exceed ~~six~~ 12 weeks within a ~~calendar~~ federal fiscal year for any individual.

340:10-2-6. Job readiness

Job readiness activities help prepare participants for work by ensuring that participants are familiar with general workplace expectations and exhibit work behavior and attitudes necessary to compete successfully in the labor market.

(1) **Orientation.** ~~Individuals~~ Participants are referred to orientation as the need is identified on Form ~~TW-2~~ 08TW002E, TANF Work/Personal Responsibility Agreement. Orientation consists of individual or group meetings ~~which are~~ designed to present information about:

- (A) self-esteem building;
- (B) activities and services available through the Temporary Assistance for Needy Families (TANF) Program;
- (C) the Oklahoma Department of Human Service (OKDHS) policies; and
- (D) the employment process, including job applications, interviewing, goal-setting, and managing home and work.

(2) **Counseling, treatment, or crisis intervention.** The worker assists ~~individuals-participants~~ who have barriers that prevent them from obtaining or retaining a job by meeting with the ~~client~~ participant and appropriate local partners to determine available resources to overcome barriers. Referrals may include counseling or treatment for:

- (A) substance abuse, medical needs, or mental health problems;
- (B) domestic violence; and
- (C) other crisis intervention.

(3) **Other activities.** TANF participants may be referred to other agencies and organizations for group activities. The worker, with input from the service provider, decides the appropriate number of hours the participant is capable of participating in other activities. Individual or group meetings may be held as necessary to address

any other needs of the participants. Topics which can be successfully addressed include:

- (A) training available from other agencies;
- (B) financial aid for education or training;
- (C) career planning for youth;
- (D) Work Experience Program participation requirements and benefits; and
- (E) local labor market information.

(4) **Educational services.** Educational services to enhance the participant's potential for employment must be made available. Assignment is based on the criteria listed in (A) through (E) of this paragraph.

(A) Custodial parent participants under 20 years of age without a high school diploma are required to participate in educational activities directed toward the attainment of a high school diploma or its equivalent. These individuals may be excused from high school attendance or courses designed to lead to a General Educational Development (GED) certificate if the employability plan includes an alternative, such as ~~Basic Education~~ basic education or English as a ~~Second Language~~ second language (ESL).

(B) Participants age 20 or older ~~who~~ that have not completed high school can participate in a basic or remedial education program.

(C) Assignment to remedial education services is appropriate for ~~individuals~~ participants who read and write below high school level, even if they have a high school diploma or GED certificate. Basic and remedial education includes Adult Basic Education (ABE) classes, GED classes, Certificate of High School Equivalency literacy classes, tutoring, or remedial reading classes.

(D) ~~Individuals~~ Participants lacking proficiency in understanding, speaking, reading, or writing the English language are assigned to ESL classes.

(E) ~~Individuals~~ Participants already in attendance at an institution of higher education are considered appropriately assigned if the ~~individual~~ participant cooperates in the assessment process and development of an appropriate employability plan. However, the ~~individual~~ participant is required to participate the minimum number of hours in an activity listed in OAC 340:10-2-1.

(F) The maximum amount of time spent in job search and job readiness activities cannot exceed 12 weeks within a federal fiscal year for any individual.

340:10-2-7. Training

(a) **Scope.** Job skills training includes vocational training and hands-on work experience to develop technical skills, knowledge, and abilities in specific occupational areas. All training programs must include qualitative measures, such as competency gains or proficiency levels, to evaluate a participant's progress and reasonable time limits for completion. Referrals are made to appropriate training facilities on Form ~~TW-308TW003E~~, Interagency Referral and Information.

(b) **Assignments.** Any training to which the participant is assigned must meet the criteria in (1) through (4) of this subsection.

(1) The hours of any training activity are governed by the training facility but must not exceed 40 hours per week.

(2) The training is preparation for a job which meets the criteria for appropriate employment.

(3) The quality and type of training must meet local employers' requirements so participants are in a competitive position with the local labor market.

(4) Training is related to in-demand occupations which are likely to become available in Oklahoma.

(c) **Work Experience Program (WEP).** The purpose of WEP is to provide skill training and work enhancement to Temporary Assistance for Needy Families (TANF) participants while providing a useful public service that will enable them to move toward self-sufficiency and obtain unsubsidized employment following completion of the placement.

(1) **Benefits.** Benefits of the program to participants include an opportunity to establish a work history and earn a recommendation from an employer. Participants also learn to balance the demands of home and work, gain confidence by performing in a job setting, brush-up skills already acquired, learn marketable skills on-the-job, and determine interest and aptitude for a particular type of work by doing the job.

(2) **WEP assignments.** WEP assignments are approved for an initial period of three months.

(A) No salary is paid.

(B) With respect to injuries incurred during working hours in WEP, federal law requires medical coverage be offered under either state workers' compensation law or by the Oklahoma Department of Human Services (OKDHS). Oklahoma workers' compensation law does not cover WEP participants. Medical coverage is provided by the Medicaid Program.

(3) **WEP referrals.** Participants are referred to WEP slots based on their employability plan. Assignment to a WEP position is coordinated between the participant and worker. Based on the employability plan, the worker determines which facility best meets the participant's needs, arranges for an interview between the facility and the participant, and notifies the participant of the place, time, and interviewer's name.

(4) **WEP facilities.** Facilities selected for WEP training must be capable of providing employment and have an apparent intent to hire, or be able to provide quality training. Training facilities are solicited by ~~Oklahoma Department of Human Services (OKDHS)~~ staff or a contracted entity who has agreed to assist with job development and placement including WEP. Local job market conditions, opportunities for employment following completion of WEP participation as well as the ability of the facility to provide the necessary supervision and training are criteria used when soliciting a facility.

(A) Training slots are developed which meet the employment needs of the participant as determined

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by the employability plan. When a facility agrees to participate in WEP, the representative of the facility is requested to provide a written description of the type of activities the participant will be involved in, the number of participants the facility can accept, the hours of participation, and any special requirements.

(B) There are two types of WEP training facilities, WEP-Nonprofit (WEP-NP) and WEP-For-profit (WEP-FP).

(i) WEP-NP placement is approved for public and private nonprofit and not-for-profit agencies, organizations, or businesses. When a participant requires additional training, the worker may approve a 60-day extension. Extensions are not granted when the primary purpose is to provide additional help to the facility. The criteria listed in subunit (I) through (VII) of this subsection are used as a guide in determining the appropriateness of requesting an extension beyond the initial three-month period.

(I) The participant needs the additional time for skills to be acquired to meet minimum hiring requirements.

(II) The participant demonstrates a willingness to learn, but needs additional training, including the development of new skills, to be competitive in the labor market.

(III) The facility has agreed to hire the participant, but will not have funds available or a job opening until a specific date.

(IV) The facility has an opening in an area different from the one the participant was trained in and has agreed to hire the participant if additional time is granted for the additional training.

(V) The participant has shown improvement in all areas, but needs additional socialization skills and improved behavior patterns in a work setting.

(VI) The participant has missed more than two weeks of training due to illness or the illness of a household member.

(VII) There are extenuating circumstances which prevented the participant from receiving full benefit of the training.

(ii) WEP-FP is approved for businesses or entities that operate for profit. Only one WEP-FP placement is allowed per 25 full-time employees in a for-profit business or entity. The criteria in subunit (I) through (II) of this subsection must be in effect prior to a WEP-FP placement.

(I) The placement matches the participant's employability plan and the career path chosen by the participant.

(II) The employer has committed to hire the participant on or before the completion of the three month placement.

(5) **WEP procedures.** Upon approval by the county director, the worker contacts the WEP facility to complete Form ~~TW-15~~ 08TW015E, Work Experience Program - Nonprofit Training Agreement, or Form ~~TW-15-A~~ 08TW115E, Work Experience Program - For-profit Profit Training Agreement.

(A) The worker instructs the facility representative or the training supervisor regarding the purpose and use of Form ~~TW-13~~ 08TW013E, Time and Progress Report.

(B) It is the participant's responsibility to complete Form ~~TW-13~~ 08TW013E, secure the signature of the facility director or supervisor on Part III of Form ~~TW-13~~ 08TW013E, and return the form to the ~~county office~~ local human services center (HSC) by the fifth day of each month.

(C) Approved training slots that have not been utilized within a six-month period are reviewed for appropriateness. If the position is no longer feasible, the county sends a letter to the facility stating the WEP slot is no longer active and may be re-evaluated at the facility's request.

(6) **Non-cooperation by WEP facility.** When information is obtained that the facility is violating the terms and conditions of Form ~~TW-15~~ 08TW015E, Form ~~TW-15-A~~ 08TW115E, or that participants are being treated unfairly, the county director is informed immediately. The nature of the allegations guides the necessary action which may include:

(A) suspension of subsequent assignments at the facility;

(B) immediate removal of current participants; or

(C) termination of the agreement.

(7) **Notification to participant and facility.** Ten calendar days prior to the anticipated WEP completion date, or at any time the participant becomes ineligible for WEP, the worker notifies the participant by letter or telephone. The worker notifies the facility by letter or by telephone five calendar days prior to the termination. When a participant has been referred to WEP and an appropriate training slot cannot be provided, the worker notifies the participant of this decision.

(8) **Changes in placements and subsequent placements.** When the facility, worker, and participant determine that placement in a different facility is more beneficial, the worker locates a new facility and arranges an interview for the participant. When the participant fails to secure employment following successful completion of WEP training, a conference is held with the participant, worker, and supervisor to determine whether a second training placement might be beneficial. The employability plan is reviewed prior to allowing a participant to re-enter WEP training. Consideration is given to reassignment to job search or another appropriate work activity. In making this decision, consideration must be given to the:

(A) participant's ability to secure and maintain full-time employment;

- (B) opportunities for employment in the new field and in the area in which the participant received training;
- (C) participant's efforts to secure employment; and
- (D) length of time between training assignments.

(d) **Job Corps nonresident training program (Job Corps II).** Oklahoma's four Job Corps centers provide a nonresident Job Corps program to TANF participants who can commute to their sites. Participants referred must be ages 16 through 24. Referrals are made by the worker completing Form ~~K-13~~ 08MP007E, Information/Referral - Social Services. It is the responsibility of the worker to coordinate with the Job Corps center and arrange for child care.

(1) By special agreement with the Job Corps centers, Job Corps II students are provided Job Corps participant training allowances designed to meet training costs not covered by the TANF cash assistance. These allowances are not considered as income.

(2) The worker coordinates with the centers and other designated agencies, such as Oklahoma Employment Security Commission (OESC) and Workforce Investment Act (WIA), to ensure Job Corps II students leaving the center are placed in an appropriate work activity. When a Job Corps II student leaves the center, the worker meets with the Job Corps II student to make immediate plans for further implementation of the employability plan.

(e) **Vocational training.** Vocational training other than that described in subsection (f) of this Section include, but are not limited to, practicum placements, internships, or proprietary schools and are considered as work activities.

(f) **Special programs and demonstration efforts with other agencies.** OKDHS may enter into special education, training, or employment efforts with federal, state, and local governments, and private for-profit, private not-for-profit organizations, and agencies. When this occurs, the counties involved are expected to comply with the terms of those agreements.

(g) **Community service.** Community service programs are structured programs in which the TANF participants perform work for the direct benefit of the community under the guidance of a public or non-profit organization.

SUBCHAPTER 10. CONDITIONS OF ELIGIBILITY - DEPRIVATION

340:10-10-4. Continued absence of the natural or adoptive parent(s) from the home

(a) **Determining absence.** Continued absence of the natural or adoptive parent(s) from the home constitutes a reason for deprivation of parental care.

(1) It is essential to determine if a primary caretaker exists or if the parents are equally sharing parental responsibilities.

(A) Only the parent determined as the primary caretaker is eligible to receive Temporary Assistance for Needy Families (TANF) for this child(ren).

(B) If both parents are exercising responsibility for the child(ren), providing day-to-day care, and share maintenance, physical care, and guidance for the child(ren), deprivation does not exist for this child(ren). ~~The child(ren) is deprived of parental care if~~ If any one of the above conditions included in the previous sentence is not met, the child(ren) is deprived of parental care.

(2) The nature of the absence must have either interrupted or terminated the parent's functioning as a provider of maintenance, physical care, or guidance for the child(ren) and the known or indefinite duration of the absence precludes counting on the parent(s) for the present support or care of the child(ren). If these conditions exist, the length of time of the absence is not considered.

(3) A parent(s) whose absence is due solely to employment, looking for employment, education, or active duty in the uniformed services of the United States, is not considered absent from the home.

(4) A parent(s) who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(b) **Identifying information.** An applicant for ~~Temporary Assistance for Needy Families (TANF)~~ must provide the name of the person(s) alleged as responsible for the support of a child(ren) and provide identifying information such as name, address, and the employer of the person(s), if known.

(1) The parent or caretaker relative completes and signs Form ~~FSS-AP-1~~ 08TA001E, Absent Parent (AP) Information Sheet.

(A) Absence is determined through an evaluation of the information recorded.

(B) If the absent parent can be located at the time deprivation is being established or at subsequent ~~re-determinations~~ reviews, the absent parent must be interviewed to determine whether deprivation exists and whether child support is being paid.

(2) When there is any question as to whether deprivation actually exists, the parent is advised that it may be necessary to obtain further evidence from persons acquainted with the situation.

(c) **Establishing need.** To establish the need for TANF, it is necessary to determine if any child support is currently being paid and, if so, the amount, how often it is paid, and the method of payment.

(1) Parents have a legal obligation to provide financial support for their child(ren), whether or not they were married to each other.

(2) ~~However, an~~ An unmarried mother is legally the sole parent until paternity is established.

(3) The termination of parental rights does not stop the obligation of either parent to provide financial support for his or her minor child(ren), unless the child(ren) has been subsequently adopted.

(4) An adoptive parent's legal obligation continues even if a child(ren) is returned to the care of the natural

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parent. ~~State law requires a referral to the appropriate district attorney if an active TANF case involves willful desertion or abandonment by the parent(s). This referral to the district attorney is made by the Child Support Enforcement Division (CSED).~~

(d) **Acknowledgment of paternity.** At any time the alleged father is located, the acknowledgment of paternity is discussed with the alleged father. The alleged father's and the mother's notarized signature are secured on Form ~~CSED 209 03PA209E, Affidavit Acknowledging Acknowledgement of Paternity.~~

(1) If the alleged father lives in the home and acknowledges paternity orally, deprivation does not exist.

(2) ~~Additionally, if~~ If the alleged father in the home denies paternity but the mother continues to maintain that he is the father, deprivation does not exist pending legal establishment of paternity.

(3) If the alleged father is under the age of 18, he must not be interviewed unless his parents, legal guardian, or natural guardian are present at the interview.

340:10-10-6. Good cause

(a) **Basis for client to claim good cause.** Although cooperation is required as a condition of eligibility for Temporary Assistance for Needy Families (TANF), federal regulations provide for waiver of that condition when such cooperation is not in the best interest of the child. However, the Oklahoma Department of Human Services (OKDHS) may determine that child support enforcement activities can be safely conducted without the cooperation of the client.

(1) It is clear that the best interests of the parent or caretaker relative are relevant to the child's best interest determination when an adverse impact on the parent or caretaker will have an adverse impact upon the child. Clearly, the physical safety and well-being of the parent or caretaker relative is in the best interest of the child. If cooperation by the mother in establishing paternity or securing support would subject her to physical or emotional harm, such cooperation would be against the child's best interest if harm to the mother is sufficiently severe to affect her ability to care for the child adequately.

(2) OKDHS determines that the client has good cause for refusing to cooperate only if:

(A) there is possible physical or emotional harm to the child;

(B) there is possible physical or emotional harm to the parent or caretaker relative-payee;

(C) the child was conceived as a result of incest or forcible rape;

(D) legal proceedings for adoption of the child are pending before a court; or

(E) the client is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(b) **Cooperation.** The cooperation requirement per OAC 340:10-10-5 is a TANF eligibility condition when there is an absent parent(s), unless the applicant has good cause for

refusing to cooperate. In all but exceptional cases, such as when it is very difficult to gather information, the good cause determination must be made with the same degree of promptness as the determination of TANF eligibility.

(bc) **Assignment and degree of promptness.** The good cause exception applies only to excuse the cooperation requirement. The requirement that the applicant or recipient per OAC 340:10-10-5 assign support rights to OKDHS as a condition for TANF eligibility;

(A) cannot be waived or excused based on a good cause determination. ~~The assignment requirement;~~

(B) is independent from the cooperation requirement; and

(C) is not affected by a good cause determination. ~~The cooperation requirement is a TANF eligibility condition when there is an absent parent(s), unless the applicant has good cause for refusing to cooperate. In all but exceptional cases, such as when it is very difficult to gather information, the good cause determination must be made with the same degree of promptness as the determination of TANF eligibility.~~

(ed) **Notice of right to request a decision.** The client has the right to claim good cause for failure to cooperate in obtaining child support.

(1) When deprivation is based on absence, the applicant for or recipient of TANF must sign Form ~~C-9 08TA012E, Cooperation Agreement and Request for Good Cause;~~

(A) at the time of original application;

(B) when a child is added to the grant; or

(C) when circumstances result in an applicant's or recipient's request for good cause.

(2) The ~~county~~ human services center (HSC) does not deny, delay, or discontinue assistance pending a determination of good cause for refusal to cooperate if the applicant or recipient has complied with the requirements to furnish evidence or information.

(de) **Responsibility of applicant or recipient.** It is the responsibility of the applicant or recipient who makes a claim for good cause to supply documentary evidence to establish the claim, or to furnish sufficient information to permit OKDHS to investigate the circumstances of good cause for refusing to cooperate. Uncorroborated statements of the applicant or recipient do not constitute verifying information as required by this regulation.

(1) The evidence must be of probative value and must be supported by written statements to the extent possible.

Examples of acceptable written statements are:

(A) birth certificate or medical or law enforcement records which indicate that the child was conceived as a result of incest or forcible rape;

(B) court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction;

(C) criminal, medical, child protective services, social services, psychological, or law enforcement records which indicate that the putative or absent parent might inflict physical or emotional harm on the child or caretaker relative;

(D) medical records which indicate the emotional health history and present emotional health status of the caretaker relative or child, or a written statement from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the caretaker relative or child;

(E) a written statement from a public or licensed private social agency that the applicant or recipient is being assisted by OKDHS to resolve the issue of whether to keep the child or relinquish the child for adoption; and

(F) sworn statements from individuals other than the client with knowledge of the circumstances which provide the basis for the good cause claim.

(2) Upon request, the worker assists the client in obtaining evidence that is not reasonably obtainable. This requirement is limited to the specific documentary evidence listed in (1)(A) through (F) of this subsection. The client must specify the type of document or record needed, as well as provide sufficient identifying information to make it possible to be obtained.

~~(e) **Title IV-E exemption.** Under limited conditions the parent(s) of a child removed from the home by a custody order may be exempt from the required referral to the CSED district office as a condition of the child's eligibility. A referral from the Children and Family Services Division (CFSD) and Office of Juvenile Affairs (OJA) includes reasons for the request of an exemption to the requirement to cooperate in the development of child support.~~

[OAR Docket #07-563; filed 3-28-07]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 40. CHILD CARE SERVICES**

[OAR Docket #07-564]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 3. Initial Application
340:40-3-1 [AMENDED]
 - Subchapter 5. Plan of Service
340:40-5-1 [AMENDED]
 - Subchapter 7. Eligibility
340:40-7-1 [AMENDED]
 - 340: 40-7-13 [AMENDED]
 - Subchapter 9. Procedures Relating to Case Changes
340:40-9-1 through 340:40-9-3 [AMENDED]
 - Subchapter 10. Electronic Benefit Transfer (EBT) System for Child Care
340:40-10-4 [AMENDED]
 - Subchapter 13. Child Care Rates and Provider Issues
340:40-13-1 through 340:40-13-3 [AMENDED]
 - 340:40-13-5 [AMENDED]
- (Reference APA WF 06-18)**

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law (P.L.) 104-193; the Balanced Budget Act of 1997, P.L. 105-33; and 45 Code of Federal Regulations (CFR) Parts 98 and 99.

DATES:

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December 15, 2006 through January 16, 2007

Public hearing:

None requested

Adoption:

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Submitted to Governor:

January 23, 2007

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January 23, 2007

Submitted to Senate:

January 23, 2007

Gubernatorial approval:

February 23, 2007

Legislative approval:

Failure of the Legislature to disapprove the rule(s) resulted in approval on March 28, 2007.

Final adoption:

March 28, 2007

Effective:

June 1, 2007

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Chapter 40, Child Care Services, rule revisions: (1) allow the use of the same application form when the client is denied benefits and then found eligible within 60 days of the original request date; (2) remove the requirement for an emergency contact; (3) permit annual reviews for benefit reporter households; (4) remove the requirement for a yearly consultation for children approved for a severe special needs rate to coincide with Division of Child Care policy; (5) add the requirement that a child care provider applying for a child care contract must provide a copy of the Oklahoma State Bureau of Investigation background investigation report; (6) add the requirement that a center provider must provide proof of employer identification number; (7) remove the requirement that a new child care provider contract must be completed when a provider changes address; (8) add clarifying information; and (9) remove out-of-date language.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 1, 2007:

SUBCHAPTER 3. INITIAL APPLICATION

340:40-3-1. Application process

(a) **Application process.** The application process for subsidized child care benefits begins with a request for an application form and ends with determining the household's eligibility and entering that determination into the computer system.

(1) **Staff responsible for processing the application.**

A Family Support Services (FSS) worker completes all applications when an eligibility determination for a family must be made. FSS workers also complete applications for children in tribal custody, children under an Interstate Compact on the Placement of Children (ICPC) with another state, or when Child Welfare (CW) staff contract with an outside agency to provide protective or preventive

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child care services. CW staff must process all applications made by CW foster parents for child care. In most instances, CW staff complete protective or preventive child care requests when they are working with the family and recommending protective or preventive child care.

(2) **When an application is required.** A new application is required when:

(A) an applicant initially applies for subsidized child care benefits;

(B) expedited eligibility processing was used in accordance with subsection (b) of this Section and requested verification is not returned within 60 calendar days of the application date;

(C) the payee for the subsidized child care benefits changes;

(D) the client's subsidized child care benefits close after approval for 30 calendar days of child care to search for a job in accordance with OAC 340:40-7-8(a)(6); or

(E) the client's subsidized child care benefits have been closed for more than 30 calendar days.

(3) **Who can apply.** An applicant or the applicant's authorized representative may apply for subsidized child care benefits. If an authorized representative applies on behalf of an applicant, he or she must bring a signed statement from the applicant giving this person permission to act on behalf of the applicant or the applicant must have designated this person as his or her authorized representative on the signed application.

(A) If the natural or adoptive parent or stepparent of the child is in the home, he or she is considered the applicant and eligibility is based on that parent's situation regardless of whether he or she has custody of the child.

(B) If both the natural and adoptive parent of the child are living in the same household and the adoption has been finalized, the adoptive parent is considered the applicant and eligibility is based on that parent's situation.

(C) If the natural or adoptive parent or stepparent is not in the home, the person acting in the role of the parent, referred to as the caretaker, is the applicant. The caretaker may or may not be related to the child.

(D) If the parent is a minor, either the minor parent or the responsible adult the minor is living with can be considered the applicant for the subsidized child care benefits. Eligibility is based on the minor parent's situation.

(E) If the natural or adoptive parent is living in the home but is too incapacitated to apply, someone else living in the home may apply for the natural or adoptive parent. The other person must provide proof of the parent's inability to apply.

(4) **Application form.** An applicant or the applicant's authorized representative completes and signs Form ~~K-2~~ 08CC002E, Application for Child Care Services, or Form ~~ESS-1~~ 08MP001E, Comprehensive Application and Review, to apply for subsidized child care benefits. When

child care is needed for a child with disabilities, the worker and applicant also complete Form ~~ADM-123~~ 08AD006E, Certification for Special Needs Child Care Rate.

(5) **Date of request.** The date of request is the date the applicant requests subsidized child care benefits verbally or in writing.

(6) **Date of application.** The date of application is the date the applicant or the applicant's authorized representative completes the child care interview and provides all necessary verification to the human services center. This includes providing the name of the child care provider the client wishes to use.

(A) The provider must already have a valid Oklahoma Department of Human Services (OKDHS) child care provider contract.

(B) See OAC 340:40-5-1(~~87~~) for reasons an applicant cannot choose certain child care providers.

(C) For applicants choosing an in-home provider, see OAC 340:40-13-1 and 340:40-13-2.

(7) **Child care interview.** Child care interviews are typically completed face-to-face with the applicant or authorized representative. A face-to-face interview is required for protective or preventive child care requests and strongly recommended for special needs requests.

(8) **Explanation of eligibility factors.** At the time of the initial interview, the worker advises the applicant or authorized representative of:

(A) his or her rights and responsibilities ~~that are included on the application;~~

(B) all factors of eligibility including which child care providers are eligible to receive subsidy payment;

(C) ~~which the plan of service and reason~~ child care providers are eligible to receive subsidy payment may be approved based on the applicant's statements at interview;

(D) ~~the need for the applicant and the authorized representative to view applicant's electronic benefit transfer (EBT) responsibilities that includes viewing the client training video. The video explains:~~

(i) ~~proper care and use of the client's electronic benefit transfer (EBT) card;~~

(ii) ~~the client's responsibility to swipe accurate attendance before OKDHS helps pay for the child's care; and~~

(iii) ~~the need to contact the worker immediately if a problem occurs so that it can be resolved within ten calendar days;~~

(E) the earliest date child care can be approved;

(~~EF~~) the requirement to cooperate with the OKDHS Office of Inspector General during any audit or investigation of the applicant or the provider the applicant uses for child care; and

(~~EG~~) the requirement to report within ten calendar days any changes in his or her circumstances.

(9) **Timeliness.** Near real-time (NRT) benefit processing time frames are used for all child care applications.

To be considered timely, the worker must determine eligibility within two working days of receiving all necessary verification to certify or deny the application. If the applicant does not provide requested verification, the worker denies the request within 30 calendar days of the date of request. The worker sends Form ~~FSS-37~~ 08MP037E, Notice Regarding Social Services, explaining the reason for delay to any applicant whose application is over 30 days old.

(10) **Right to appeal.** The applicant has the right to appeal the untimely processing of a child care request or the decision of eligibility or ineligibility per OAC 340:2-5.

(b) **Expedited eligibility processing.** The worker must process an application immediately when required verification is beyond the applicant's control to provide, the applicant does not have the money to pay toward the cost of child care, and without child care the applicant:

- (1) is in danger of losing a job; or
- (2) cannot start a new job.

(c) **Eligibility determination.** The worker uses OKDHS Appendix C-4, Child Care Eligibility/Rates Schedule, to determine whether the household meets income guidelines. See OAC 340:40-5-1(98) for more information about income determination.

(1) **Applicant determined eligible.** The earliest date the worker approves subsidized child care benefits is the date the applicant provides all necessary verification to determine eligibility. The applicant is responsible for any child care used before the certification date or which is not part of the approved child care plan of service.

(A) Once care is approved, the client swipes attendance with his or her EBT card through a point-of-service (POS) machine at the child care facility.

(B) OKDHS does not pay for care for any day the child attends child care if the client fails to swipe attendance unless extenuating circumstances exist beyond the control of the client and/or provider.

(C) If the client fails to swipe attendance, he or she is responsible for any care given for that day and may be responsible for any absent day payment OKDHS pays if all days the child attended were recorded.

(2) **Applicant determined ineligible.** The request or application is denied if the applicant is ineligible, does not provide needed verification, or requests cancellation of the application. A new application form is not needed when the applicant completes the application process and provides necessary verification within 60 calendar days of the original request date.

SUBCHAPTER 5. PLAN OF SERVICE

340:40-5-1. Plan of service

Plan of service. Providing child care is part of an overall plan of service designed to help the parent or caretaker with whom the child lives to achieve his or her maximum potential for self-support. Quality child care services assure the parent or caretaker that each child has adequate care that affords

developmental and learning experiences while the parent or caretaker is engaged in self-support activities. The plan of service consists of many components that all link to form a goal-directed plan of care, and includes the components in (1) through ~~(1211)~~.

(1) **Child characteristics.** The worker gathers information about the child for whom child care is needed including his or her name, age, grade level, and whether the child has a disability.

(2) **Need for child care.** The worker determines whether the parent or caretaker meets a need factor in accordance with OAC 340:40-7-7 and 340:40-7-8.

(3) **Plan hours.** The worker gathers information about the days and hours the parent or caretaker meets the need factor, including travel time. When there are two parents or caretakers in the home, the worker only approves subsidized child care benefits ~~for the hours~~ when both parents or caretakers meet a need factor during the same hours in accordance with OAC 340:40-7-7 and OAC 340:40-7-8. Based on the days and hours the child requires care, the worker approves a full-time daily, part-time daily, a combination of full-time and part-time daily, weekly, or a blended unit type.

(4) **Alternative to subsidized child care benefits.** The worker explores with the client whether there is an appropriate, feasible alternative to Oklahoma Department of Human Services (OKDHS) subsidized child care benefits. If the alternative is a spouse or the natural or adoptive parent of the child who lives in the home, the client must use the alternative rather than subsidized child care benefits. If the alternative is someone else, the client has a choice whether to use this alternative or not. Possible alternatives include:

- (A) care by a dependable relative who is able and willing to assume responsibility for care and supervision of the child for part of the day;
- (B) care in a free or low cost facility, such as a preschool, pre-kindergarten, kindergarten, Head Start, Early Head Start, or tribal child care program;
- (C) dependent care expenses that are considered as earned income exemptions, per OAC 340:10-3-33(3); and
- (D) for a school age child, the rearrangement of the parent's or caretaker's employment or training schedule to coincide with the hours the child is in school.

(5) **Plan to increase income.** At each application or review the client and worker discuss ways the client can increase income to the household and identify the goals child care helps the family achieve. Together they estimate when the family can assume progressively greater responsibility for the cost of child care. The worker makes referrals to other agencies as appropriate and in accordance with OAC 340:40-7-9.

(6) **Back up plan.** The worker discusses with the client the back up plan for child care that is in place if the child cannot go to the usual provider because of illness, school holidays, or other unforeseen emergency. The back up plan includes the name and address of a person the client

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feels he or she can rely on when the normal plan of care cannot be used.

~~(7) **Emergency contact.** The worker records on the application or review form the name, address, and telephone number of a person to call in case of an emergency when the primary parent or caretaker cannot be reached.~~

(87) **Choice of provider.** The worker documents the choice of provider on the application or review form. If the client does not choose a provider at the time of request, the worker provides the client with information to help in making the choice. The client may choose a family child care home regardless of star level. The client may not choose a child care:

(A) facility that does not have a valid contract with OKDHS;

(B) facility in which the client or his or her spouse, including the child's parent or stepparent, has an ownership interest;

(C) home in which the child resides;

(D) home in which the client also works during the hours his or her child(ren) is in care unless an approval is obtained from the Family Support Services Division (FSSD), Child Care Section;

(E) provider who does not allow parental access during the hours the provider is caring for children;

(F) provider who is receiving state or federal funds, such as Head Start, Early Head Start, or public schools, unless:

(i) all parents are charged a fee for the hours subsidy payment is requested; and

(ii) the program offers extended day services. Programs operating only during typical school or Head Start hours are not eligible;

(G) provider caring for a school age child during the regular school day when such student could be attending a public or private school during those hours; or

(H) center, which is a one star facility unless there are no one plus, two, or three star centers in the community or special exception criteria are met. Special exception criteria are:

(i) the child was already approved for care at this one star center prior to January 1, 2003 or prior to the provider's star status being reduced to one star. The child can remain at this facility unless the child stops attending there for more than 30 calendar days. The child may be approved at this same facility again if the only reason the child did not attend for more than 30 calendar days was because of a school break or due to circumstances beyond the control of the family such as illness of the child;

(ii) care is requested for a child living in the same home as a child already approved for care as described in (I)(i) of this subsection for the same one star child care provider; or

(iii) the parent or guardian demonstrates there is no other child care option that meets the family's needs.

(98) **Income determination.** Based on OAC 340:40-7, the worker determines who is considered part of the household for income determination, what income is countable, and what income is excluded. After determining the amount of countable household income, the worker uses OKDHS Appendix C-4, Child Care Eligibility/Rates Schedule, to determine whether the household meets income guidelines. The OKDHS Appendix C-4 is amended from time to time and the Commission for Human Services must approve any changes. If the income of the family exceeds the eligibility standard on the appendix or is above the income level on the appendix, the family is not eligible for subsidized child care benefits.

~~(102)~~ **Family share co-payment.** The worker uses OKDHS Appendix C-4 to determine the family share co-payment for each family. The family share co-payment is applied before OKDHS pays a child care subsidy. The amounts the family and OKDHS pay toward the cost of care varies depending on the plan of service, family size, income, and the number of children receiving subsidized child care benefits.

~~(110)~~ **Social services requests.** When a client requests help in meeting the social services needs listed on the application or review form, the worker provides all available information to aid a client in meeting these needs.

~~(121)~~ **Client rights and responsibilities.** The worker advises the client of rights and responsibilities listed in (A) through (H).

~~(A) The client has the right to an explanation by the worker of the "Client Child Care Responsibilities and Service Plan Agreement" listed on Form FSS 1, Comprehensive Application or Review, or Form K 2, Application for Child Care Services, before signing the form.~~

~~(B)~~ A child care request is only approved back to the date of request when the interview is conducted and verification is provided on that same date.

~~(C)~~ The client has the right to ask for a fair hearing if the client disagrees with an action taken on his or her case, per OAC 340:2-5.

~~(D)~~ The provider may charge the client for special fees, such as enrollment or transportation fees, provided these fees are posted and also charged to the general public.

~~(E)~~ The provider may charge the client for care provided in excess of OKDHS approved child care plan of service hours when the client chooses to leave the child in care longer. If the provider requires that all children in the facility begin care by a certain time of day and the client's child care plan hours start later, the provider must not charge the client for those additional hours. The client swipes attendance based on the child care plan hours.

~~(F)~~ The provider may charge the client for any days OKDHS refuses to pay for care when:

- (i) the client did not swipe attendance for the correct days and times his or her child attended child care;
 - (ii) swipes were denied and the client did not get them corrected within ten calendar days; or
 - (iii) the provider loses the absent day payment for a child approved for a weekly unit type because the client did not swipe correct attendance for every day the child attended that month.
- (GF) The provider may not charge the client for:
- (i) days and hours covered in the child care plan when all attendance was correctly swiped even if the hours are more than customary for a full-time day; and
 - (ii) days the child is not in attendance.
- (HG) The client is required to cooperate with the OKDHS Office of Inspector General in any audit or investigation of possible overpayments by the client or by the client's chosen provider.

SUBCHAPTER 7. ELIGIBILITY

340:40-7-1. Categories of eligibility

A person may be predetermined eligible for a child care benefit, determined income eligible based on the gross income of the household, or have dual eligibility with his or her tribe.

(1) **Predetermined eligible.** A person is predetermined eligible for a child care benefit with a zero co-payment when he or she is a recipient of public assistance or Supplemental Security Income (SSI) ~~and the parent or guardian requesting the child care benefit for the child is also the payee on the public assistance payment for the child.~~ Public assistance is defined as a State Supplemental Payment, Temporary Assistance for Needy Families (TANF) that includes Supported Permanency and non-cash vouchers a child receives from the TANF program, or Refugee Cash Assistance. ~~This definition also includes non-cash vouchers a child receives from the TANF program per OAC 340:10-3-56(3)(k).~~

(A) All TANF recipients who go to work and are eligible for a child care benefit can choose to receive a child care benefit through the Oklahoma Department of Human Services (OKDHS) while they work or choose to pay for the child care themselves. If they choose to pay for the child care cost themselves, it can be considered as an earned income exemption for the TANF benefit.

(B) Exceptions to a person being eligible with a zero co-payment when he or she receives public assistance or SSI include:

- (i) when the recipient is a child and the parent or guardian requesting the benefit for the child is not the payee on the public assistance or SSI payment; or
- (ii) when it makes a difference in whether other children in the household are income eligible for child care.

(2) **Income eligible.** Households who are not predetermined eligible for a child care benefit must meet income eligibility guidelines shown on OKDHS Appendix C-4, Child Care Eligibility/Rates Schedule, for their household size, to receive assistance with child care costs.

(3) **Transitional child care.** Per Section 230.61 of Title 56 of the Oklahoma Statutes, a TANF recipient who becomes employed is eligible for transitional child care benefits for 24 months following the date of employment as long as he or she meets income eligibility guidelines on OKDHS Appendix C-4 for his or her household size unless:

- (A) the employer provides child care benefits; or
- (B) the monthly salary received from the employer exceeds the monthly allowance of assistance pursuant to the TANF program plus the cost of child care and medical insurance to which the recipient would be entitled.

(4) **TANF families in the Work Supplementation Program.** TANF families in the Work Supplementation Program are considered income eligible families and must meet income eligibility guidelines shown on OKDHS Appendix C-4 for their household size, to receive assistance with child care costs.

(5) **Dual eligibility.** An individual may have dual eligibility for both the child care subsidy program through OKDHS and through his or her tribe. The child care provider may not receive payment from both programs simultaneously. The client may be approved for the child care subsidy program and the tribe may pay the client's family share co-payment.

340:40-7-13. Computation of income

(a) Any income that is received regularly but in amounts that vary, or income received irregularly, is averaged over a minimum of 30 days unless the client has received less than 30 days of representative income. This includes overtime pay, irregular child support, and other occasional increases or decreases in the monthly gross income. When income is received more often than once per month, the income is converted to a monthly amount.

(b) Income of the applicant or recipient is verified by the best available information. With new employment, the worker verifies the beginning date, date the first full paycheck is expected to be received, hourly rate, and anticipated number of hours per week.

(c) All earned and unearned income is added together to arrive at the gross income for the household.

(d) Once gross income is computed, the only allowable deduction from gross income is for the amount of any verified legally-binding child support payments paid by a household member to or for a non-household member, including child support and child care support payments made to a third party on behalf of the non-household member.

(e) The worker uses Oklahoma Department of Human Services (OKDHS) Appendix C-4, Child Care Eligibility/Rates Schedule to determine whether the household meets income guidelines. See OAC 340:40-5-1(~~h~~8).

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SUBCHAPTER 9. PROCEDURES RELATING TO CASE CHANGES

340:40-9-1. Review of child care eligibility

(a) **Child care review.** The worker completes a review of all conditions of eligibility for subsidized child care benefits no later than 12 months from the date of approval of the application or from the last review. When the need factor for child care is for a protective or preventive reason, child care is reviewed more often in accordance with OAC 340:40-7-8(e). The client or the client's authorized representative completes and signs Form ~~FSS-1 08MP001E~~, Comprehensive Application and Review, or Form ~~K-2 08CC002E~~, Application for Child Care Services. If the client is a semi-annual benefit reporter as described in subsection (b) of this Section, Form ~~FSS-BR-1 08MP004E~~, Benefit Review Report, may also be used as a review form for subsidized child care benefits. When circumstances change between review months, the worker evaluates whether to make a change to the client's family share co-payment and/or plan of service or ~~whether a to complete Form FSS-1 08MP001E or K-2 08CC002E is required.~~

~~(1) A complete application/review form is required when:~~

- ~~(A) the payee on the child care benefit changes;~~
- ~~(B) the client's subsidized child care benefits closed because a period of job search was given in accordance with OAC 340:40-7-8(a)(6) and the client finds employment; or~~
- ~~(C) subsidized child care benefits must be synchronized with the client's food benefits or Medicaid benefits in accordance with subsection (c) of this Section.~~

~~(2) The client completes only the last page of Form FSS-1 or K-2 when:~~

- ~~(A) the days and hours child care is needed changes;~~
- ~~(B) the client requests a child be added to the subsidized child care benefits and that child's plan of service is different than the other children already approved for subsidized child care benefits. Policy regarding adding children is found at OAC 340:40-9-2(b); or~~
- ~~(C) the client's Temporary Assistance for Needy Families benefit closes and there is a continued need for subsidized child care benefits.~~

(b) **Semi-annual reporting Benefit reporter households.** If a client receiving subsidized child care benefits is also receiving food benefits and/or Medicaid and is considered a semi-annual benefit reporter for one or both of these programs, the client is considered a semi-annual benefit reporter for the Child Care Program.

(1) Semi-annual reporters Benefit reporter households are sent a computer-generated Form ~~FSS-BR-1 08MP004E~~ in the fifth or the 11th month of certification depending on whether the client is a semi-annual or an annual reporter for the other program, and every six months thereafter. The client will continue to receive a 08MP004E every fifth or 11th month thereafter as long

as the subsidized child care benefits remain active and the client remains in benefit reporting status.

(2) Form ~~FSS-BR-1 08MP004E~~ asks households to report changes in the household's circumstances that could affect their benefits. Form ~~FSS-BR-1 08MP004E~~ must be completed and returned to the human services center, along with all required verification, by the last day of the sixth or 12th month of the review period or the subsidized child care benefits automatically close.

(3) If the household fails to provide sufficient information regarding a deductible expense, continued eligibility is determined without regard to the deduction.

(4) The worker must act on any changes reported on the ~~FSS-BR-1 08MP004E~~ in a timely manner.

(c) **Synchronization of benefits.** When the client is receiving other benefits from the Oklahoma Department of Human Services (OKDHS) in addition to the subsidized child care benefits, certification and review dates must be coordinated with the other programs.

340:40-9-2. Case changes

(a) **Case changes.** The client must report within ten calendar days any changes in his or her circumstances that would result in an increase or decrease in subsidized child care benefits. The worker acts on changes that increase or decrease the subsidized child care benefits regardless of whether the client is a semi-annual reporter or not. Failure to report changes timely may result in an overpayment assessment against the client. Examples of changes the client must report include:

- (1) household income;
- (2) household composition;
- (3) names and number of household members in child care;
- (4) the reason child care is needed;
- (5) parent's or caretaker's work or school schedule or any other change affecting the days and hours child care is needed;
- (6) the client's address or telephone number;
- (7) the child care facility the child is attending;
- (8) child care is no longer being used or needed; and
- (9) family size.

(b) **Additional child request.** When an additional child requires subsidized child care benefits, the worker completes the request within two working days of the client providing all necessary verification to determine eligibility. ~~The client completes the last page of Form FSS-1, Comprehensive Application and Review, or Form K-2, Application for Child Care Services, only when the days and hours this child needs subsidized child care benefits differs from the current plan of service.~~ If eligible, the child can be approved for subsidized child care benefits beginning with the date of request. Family share co-payment increases due to adding an additional child to the subsidized child care benefits are effective the month after the month the client requests subsidized child care benefits for that child.

(c) **Changes that increase the subsidized child care benefits.** When the client reports a change timely that increases the subsidized child care benefits, the client and the worker jointly

plan the effective date of the change. When the client does not report changes timely, the earliest date the worker increases the subsidized child care benefits is the first day of the month in which the client reports the change.

(d) **Changes that decrease the subsidized child care benefits.** When possible, the worker plans with the client changes that decrease the subsidized child care benefits before implementing the change. When the client reports an increase in income, the worker uses Oklahoma Department of Human Services (OKDHS) Appendix C-4, Child Care Eligibility/Rates Schedule, to determine whether the household meets income guidelines in accordance with OAC 340:40-5-1(98).

(e) **Change in provider.** When a client reports a change in provider, the change is effective the date the change in provider occurs, regardless of whether or not the client reports this change timely. The worker completes provider changes within two working days of the date the client reports the change.

(f) **Closure of the subsidized child care benefits.** When advance notice is required, the worker closes the subsidized child care benefits ten days from the date action is taken. Ten day advance notice is not required when the client gives written permission agreeing to an earlier closure date.

(g) **Reopen action.** When a client's subsidized child care benefits close, they can be reopened using current eligibility information if policy and procedures were not administered correctly or if human services center staff receive new or additional information within 30 calendar days of the effective date the benefits terminated that shows the family continues to be eligible. The client must complete a new application when:

- (1) a 30 calendar day period of job search was given because the client lost his or her job or successfully completed school and the subsidized child care benefits were closed;
- (2) expedited eligibility processing is used and requested verification is not returned within 30 calendar days of the application date. See OAC 340:40-3-1(b); or
- (3) the payee for the child care case changes.

340:40-9-3. Notices regarding child care eligibility

(a) **Computer-generated notice required.** A computer-generated notice is sent to inform the client of any:

- (1) initial eligibility decision;
- (2) decision regarding continued eligibility if a change occurs that increases or decreases the level of subsidized child care services benefits;
- (3) decision to terminate subsidized child care services benefits; and
- (4) decision to reopen subsidized child care services benefits.

(b) **Form ~~FSS-37 08MP037E~~, Notice Regarding Social Services, required.** The worker must send Form ~~FSS-37 08MP037E~~ when the system does not provide a notice. The worker also sends Form ~~FSS-37 08MP037E~~ to notify the client and provider when any additional co-payment is being paid by someone other than the client directly to the provider or is being discounted by the child care provider for an employee.

(c) **Notice not required.** A written notice is not required for:

- ~~(1) information and referral services; and~~
- ~~(2) protective intervention services.~~

(d) **Returned notices.** When a notice of a proposed case action is returned, the worker makes at least one attempt to locate the client.

(e) **Advanced notice required.** Advanced notice is required on case actions that decrease or terminate the level of child care services when such services are still needed by the client.

(f) **Advance notice not required.** Advance notice is not required on case actions that increase the level of child care services or when child care services are no longer being used.

SUBCHAPTER 10. ELECTRONIC BENEFIT TRANSFER (EBT) SYSTEM FOR CHILD CARE

340:40-10-4. Child care electronic benefit transfer (EBT) payment process

(a) **Child care payments.** The Oklahoma Department of Human Services (OKDHS) makes payments for child care services to providers electronically using the EBT system unless the provider is an in-home provider; or a provider on a military base; ~~or an out of state provider.~~ These providers are paid manually via the EBT system after submitting Form ~~ADM-12-S-10AD121E~~, Child Care Claims.

(b) **Point-of-service (POS) machines.** Contracted child care providers are issued a POS machine within ten days of the date the worker authorizes care for a child and the provider notifies the OKDHS contractor that he or she is beginning to care for a child eligible for an OKDHS subsidy.

(c) **Attendance swiping.** Clients record actual times their child attends child care by swiping an EBT card through the POS machine. Providers can charge clients for care provided on days they fail to bring their EBT card or when the machine message shows care is denied. If care is later approved for that date(s), the provider must reimburse the client for any care paid for by the client above the family share co-payment.

(1) Providers must monitor the POS machine to ensure correct attendance times are recorded. If incorrect times are recorded, the provider can void the incorrect transaction and ask the client to start over.

(2) When clients forget to swipe their EBT card for a day their child attends care, record incorrect times that are voided by the provider, or receive a denied error message, the system allows the client to swipe previous in and out times for the current day and the previous nine days.

(3) Based on attendance recorded and the level of care authorized, electronic settlements to providers are made weekly.

(d) **EBT payment week.** The EBT payment week begins every Sunday at 12:01 A.M. and ends every Saturday at midnight. Electronic settlements are made each week in the provider's designated financial institution account on Tuesday morning for services provided two weeks prior to the current week. If the financial institution is closed on Monday or Tuesday or Monday is a holiday, the electronic settlement is deposited on Wednesday morning.

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(e) **Manual claims process.** When the provider reports he or she was not paid correctly, he or she can submit Form ~~ADM-12-S 10AD121E~~ or ask the client's worker to submit Form ~~EBT-4-10EB004E~~, Report of EBT Child Care Payment Adjustments, to the Finance Division for a manual adjustment. The provider waits to submit Form ~~ADM-12-S 10AD121E~~ until approximately the 20th of the next month. Finance Division staff evaluate whether to adjust payment to the provider based on why care was not paid electronically.

(1) If the client did not attempt to record attendance electronically, no payment is made to the provider for days swipes are not recorded unless extenuating circumstances beyond the client's and/or provider's control exist. These extenuating circumstances must be documented on Form ~~ADM-12-S 10AD121E~~.

(2) If the client swiped correct attendance times but swipes were denied in error, Finance Division staff make manual adjustments.

(3) If the family share co-payment applied by the EBT system was incorrect, Finance Division staff make manual adjustments.

(4) If the provider was paid the wrong rate either because of incorrect coding of the child care plan, an incorrect birth date shown for a child, or an incorrect star status paid, Finance Division staff make manual adjustments.

(f) **Absent day payments.** Providers can be paid an absent day payment for a child who misses some days of scheduled attendance and is authorized for ~~care on a weekly basis unit type~~. An absent day payment is electronically deposited in the provider's account in their weekly settlement received after the tenth of the month following the month care was given. To be eligible to receive this additional payment, the child must be approved for a weekly ~~authorization-unit type~~ and ~~must~~ attend the minimum number of full-time days shown on OKDHS Appendix C-4-B, ~~Guidelines for Weekly Authorizations Unit Type Guidelines~~, for that month. The provider is not eligible for an absent day payment if the child did not attend the minimum number of full-time days for that calendar month or attended the maximum days paid that is also shown on OKDHS Appendix C-4-B. The formulas used to determine the minimum number of days the child must attend to qualify for an absent day payment are:

(1) three-day work week equals the number of days in the individual month minus the greater number of days for four days per week minus three;

(2) four-day work week equals the number of days in the individual month minus the greater number of days for three days per week minus four;

(3) five-day week equals the number of days in the individual month minus the greater number of days for two days per week minus five;

(4) six-day week equals the number of days in the individual month minus the greater number of days for one day per week minus five; or

(5) seven-day week equals the number of days in the individual month minus five.

SUBCHAPTER 13. CHILD CARE RATES AND PROVIDER ISSUES

340:40-13-1. Child care arrangements

(a) **Out-of-home care arrangements.** Out-of-home care is care provided outside of the child's home for less than 24 hours. The Oklahoma Department of Human Services (OKDHS) purchases out-of-home child care services only from licensed or permitted child care centers and family child care homes. A list of licensed, contracted out-of-home providers is available upon request.

(b) **In-home child care arrangements.** OKDHS purchased in-home child care services are obtained only from approved in-home providers. In-home child care is considered the arrangement of choice when night-time child care is needed or when care is needed for a medically fragile child. A parent can choose an in-home provider even when an out-of-home provider is available. In no instance is housekeeping service approved. The approval is for the child care plan and the individual giving care.

(1) The worker helps the family select a caregiver capable of providing adequate care and supervision of the child(ren). Guidelines for use in approving an in-home provider are found at OAC 340:40-13-2.

(2) Upon selection of a caregiver, the client and caregiver complete Form ~~CCDF-2-08CC003E~~, Notification of Eligibility and Mutual Agreement to Provide In-Home Child Care Services. This form is valid for a maximum of one year from the date the county director signs the document and must be renewed annually. If the chosen caregiver is not approved as an in-home provider, the county director sends a letter to the caregiver advising of the denial. The worker sends Form ~~FSS-37 08MP037E~~, Notice Regarding Social Services, to the client advising him or her to choose another caregiver.

(3) The client and provider also complete and return Form ~~CCDF-2-A 08CC004E~~, Mutual Agreement Regarding the Plan of Care. This form serves as a basis for discussion between the parent or caretaker and the in-home provider of the plan of care for the children, duties of the in-home provider, how to handle emergencies, and the family rules.

(4) To help ensure the health and safety of the child(ren) in care, the worker gives Form ~~CCDF-2-B 08CC005E~~, In-Home Provider Health and Safety Checklist, to the provider and the client to complete and return to the worker when the initial contract is signed. The parent or caretaker is also responsible for advising the provider of known risks of a contagious condition of one or more persons in the household. The disclosure allows for training in the universal precautions against exposure.

(5) The in-home provider is required to review the "Contracting with DHS for Child Care Subsidy Payments Handbook" and watch a training video prior to approval as an in-home provider.

(6) The in-home provider must complete a minimum of six clock hours of training within 90 calendar days of the date the county director signs and dates Form ~~CCDF-2~~

08CC003E. The provider can meet the training requirement by attending workshops or formal training programs, viewing videos, or through individual job related readings. The in-home provider must then sign and complete Form ~~FSS-DC-IN-1~~ 08CC008E, Declaration of Completion of In-Home Provider Training, and return it to the worker.

(A) The in-home provider must receive and declare six clock hours of training yearly. The declaration is valid for one year from the date the provider signs the document.

(B) Training hours earned by the in-home provider are transferable from one family to another during the year the declaration is in force.

(7) When an in-home child care provider cares for a child with disabilities, the provider can be approved for the special needs rate in addition to the applicable daily rate. Prior to receiving this additional rate:

(A) the client, provider, and worker must complete Form ~~ADM-123~~ 08AD006E, Certification for Special Needs Child Care Rate, as described in OAC ~~340:40-7-8(h)~~ 340:40-7-3.1;

(B) the provider must be currently certified in first aid and infant and child cardiopulmonary resuscitation (CPR). Only training that is OKDHS approved, such as Red Cross, American Heart Association, or First Care is accepted;

(C) the provider must receive on-site consultation regarding the nature of the child's disability and the development of the child care plan ~~described in Section III of Form ADM-123~~ which may include how to operate equipment needed by the child and any specialized training needs. This consultation can be provided by a health professional, a child guidance specialist, a SoonerStart provider if the child is under three years of age, a public school teacher familiar with that child, or from a consultant through the Center for Early Childhood Professional Development. The consultant also provides any available resource materials that might aid the provider in caring for the child. ~~For a child designated as "severe," consultation shall be obtained at least annually;~~ and

(D) the provider must agree to obtain six additional hours of training in areas that address the care of children with disabilities within six months of approval. First aid, CPR, or informal training may not be counted to meet the special training requirement. Recommended training includes Special Care's Unique Environments, Child Care Careers' Helping Children with Special Needs, SoonerStart training, Training Inclusive Child Care Equal Terrific Opportunities for Children (TIC-TOC) training, formal training from an OKDHS approved sponsor training list, or specialized workshops or conferences addressing the care of children with disabilities. This training is also documented on Form ~~FSS-DC-IN-1~~ 08CC008E.

340:40-13-2. Guidelines for use in approving in-home child care

(a) **Purpose.** In-home child care is defined as care given to a child(ren) by a person coming into the child's own home for the express purpose of caring for the child(ren). The purpose of standards for in-home care is to help ensure the safety of children cared for in their own home when the usual responsible adult is temporarily absent due to employment, training, illness, or other valid reason.

(b) **Qualifications of caregiver.** The caregiver:

- (1) must be at least 18 years of age;
- (2) demonstrates the vitality and flexibility needed to care for children as well as the ability to exercise good judgment and appropriate authority;
- (3) must provide personal references prior to approval if, in the worker's judgment, they are considered necessary;
- (4) cannot be a member of the child's household, whether relative or non-relative. An exception is made if the person is employed full-time and if approved as a provider, agrees to quit his or her employment; and
- (5) can only care for the child(ren) of one family at a time. The provider can give care to more than one family as long as the hours do not overlap and the child(ren) of each family is cared for in his or her own home.

(c) **Background investigations and restrictions for caregivers.** The requirements for background investigations and restrictions for caregivers are contained in paragraphs (1) through (3) of this subsection.

(1) **Criminal history investigations.** Criminal history investigations:

- (A) are required and must be requested by each caregiver and substitute caregiver, prior to caring for children;
- (B) are not required for persons who have documentation of a criminal history investigation within the last 12 months;
- (C) must be obtained from:
 - (i) the Oklahoma State Bureau of Investigation (OSBI); and
 - (ii) the authorized agency in the previous state of residence if the individual has resided in Oklahoma less than one year;

(D) must include a search of the Oklahoma Department of Corrections' files maintained by the OSBI pursuant to the Sex Offenders Registration Act; and

(E) include the worker completing a computer check using the Social Security number of the potential caregiver prior to approval as an in-home provider. When a Child Welfare (CW) case number appears, the worker consults with CW staff to see if concerns exist about this person's ability to care for children.

(2) **Restrictions.** A caregiver whose criminal history report includes a conviction of fiscal mismanagement, such as embezzlement or fraud, or repeated convictions that indicate a pattern of criminal activity is not approved as an in-home provider. Individuals who are convicted of or enter a plea of guilty or nolo contendere, no contest, to

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certain crimes are not approved to care for children or be a substitute caregiver. These crimes include:

- (A) violence against a person;
 - (B) child abuse or neglect;
 - (C) possession, sale, or distribution of illegal drugs;
 - (D) sexual misconduct; or
 - (E) gross irresponsibility or disregard for the safety of others.
- (3) **Alcohol, drugs, medication.** The caregiver must not be under the effects of alcohol, illegal drugs, or medication that impairs functioning when caring for children.
- (d) **Duties of the caregiver.** The caregiver:
- (1) provides adequate care and supervision of children at all times, including frequent observations of children in cribs or playpens. He or she must arrange to have a competent adult provide consistent supervision during his or her absence from the home;
 - (2) is responsible only for each child specified in Form ~~CCDF-2 08CC003E~~, Notification of Eligibility and Mutual Agreement to Provide In-Home Child Care Services;
 - (3) must be aware of adequate safety precautions and take action to correct hazards to children's safety, both indoors and outdoors;
 - (4) provides opportunities for learning, indoor and outdoor play, rest periods, and meals. The caregiver ensures that the use of television is age-appropriate and suitable for children;
 - (5) must be able to give understanding, consistent, and loving guidance. Discipline is constructive and educational in nature and appropriate to the child's age and circumstances. Loud, profane, and abusive language, corporal punishment, or any technique that is either humiliating or frightening to children is not used. Discipline is not associated with rest, toilet training, or loss of food;
 - (6) seeks emergency medical attention in case of sudden illness or accident. The parent or guardian stipulates who is called in case of an emergency by entering this information on Form ~~OC-38 07LC038E~~, Child Information Form, provided by the Oklahoma Department of Human Services (OKDHS). The caregiver has emergency telephone numbers readily available at all times. Emergency telephone numbers include the fire department, police department, ambulance service, and physician or clinic;
 - (7) is responsible for preparation and serving of food. The child's family provides the food used to prepare snacks and meals. The caregiver consults with the child's parent(s) or guardian to ensure a balanced diet suitable to the age and physical development of the child; and
 - (8) ensures the child's school attendance in accordance with the requirements of the State Department of Education.

340:40-13-3. Child care payments and rates

- (a) The Oklahoma Department of Human Services (OKDHS) contracts to purchase out-of-home child care services for children only with licensed providers who:
- (1) post rates and fees;

- (2) sign and comply with all the terms of Form ~~CCDF-1-E 08CC001E~~, Child Care Provider Contract;
 - (3) have participated in mandatory contract training; and
 - (4) have access to an account at a financial institution for electronic benefit transfer (EBT) purposes.
- (b) In accordance with Section 85.44B of Title 74 of the Oklahoma Statutes, OKDHS cannot make advance payments to child care providers.
- (c) The rates paid by OKDHS are determined by:
- (1) the child's age;
 - (2) settings in which the care is provided:
 - (A) the child's own home;
 - (B) a child care center; or
 - (C) a child care home;
 - (3) whether the child has disabilities and the provider is approved for the special needs rate unit type. The special needs rate is added to the applicable rate a child care provider receives for a typical child of the same age after the Form ~~ADM-123 08AD006E~~, Certification for Special Needs Child Care Rate, approval process is followed;
 - (4) whether the care is provided full-time, over four hours per day or part-time, four hours or less per day;
 - (5) whether the worker approves a full-time daily, part-time daily, a combination of full-time and part-time daily, blended, or a weekly unit type;
 - (6) the county in which the provider is located; and
 - (7) whether the facility qualifies for a differential quality rate.
- (d) The in-home child care rate is paid for children cared for in their own homes. The in-home rate is 90% of the one star child care home daily rate shown on OKDHS Appendix C-4, Child Care Eligibility/Rates Schedule, for the child's age. If a child is eligible for the severe or moderate special needs rate, this additional amount is added to the applicable in-home rate for that child.
- (e) When the child is cared for in an out-of-home child care center or home, the allowable rate is the amount as shown on OKDHS Appendix C-4.
- (f) Care may only be authorized at one facility per day per child. If the client uses care at two different providers for the same day for the same child, OKDHS staff approves care at only one of the facilities. The parent or caretaker can use care at two different providers for the same child when care is needed on different days of the week.
- (g) Charges are authorized and payment is made only when the care provided is in accordance with the jointly developed plan of service between the client and OKDHS.
- (h) Age-driven rate changes are effective the first of the month following the child's birth date except as shown in (i) of this Section.
- (i) Eligibility for a child stops the day before:
- (1) a typical child reaches age 13; or
 - (2) a child with disabilities or a child in OKDHS custody reaches age 19.
- (j) A change to add the higher special needs rate to the applicable daily rate is effective the first of the month following the month eligibility for this rate is determined.

(k) A child care provider may be approved for a differential quality rate if he or she meets the criteria for this rate. This rate is given effective the first of the month following the month Division of Child Care (DCC) licensing staff approves the provider for the rate. The rate is designated on OKDHS Appendix C-4 by its star status.

(l) The traditional school year blended rate may be approved for children age four and older from August 16th through May 15th each year for children attending public school, a pre-kindergarten program, or Head Start during the traditional school year. The extended school year blended rate may be approved for the full calendar year when children attend school the entire year.

340:40-13-5. Child care provider contracts

(a) **Criteria.** In order for the Oklahoma Department of Human Services (OKDHS) to purchase out-of-home child care services, a provider must have a current Form ~~CCDF 1-E 08CC001E~~, Child Care Provider Contract, signed by both the owner of the facility and the OKDHS Director or designee on file with the Family Support Services Division (FSSD) Child Care Section. OKDHS assures all persons that OKDHS or any provider of contractual services, does not take into account a person's race, color, religion, sex, national origin, or disability in the selection or eligibility of individuals to receive services and in the manner of providing them. Age may be a factor only to the extent that certain services are designed for a particular age group.

(1) Written complaints of noncompliance with the assurance in (a) of this Section may be made to the Director of OKDHS or to the Secretary of Health and Human Services, Washington, D.C. 20201.

(2) Local Division of Child Care (DCC) licensing staff provide initial information about contracts for child care facilities. The provider contacts the child care liaison to request a contract.

(3) Child care contracts are valid for a maximum of one year. They are automatically renewed for successive one year terms, under the same terms and conditions, unless either the child care provider or OKDHS gives written notice of its intent not to renew to the other party at least 30 calendar days prior to the expiration of the current term.

(b) **Procedure for obtaining child care contracts.** OKDHS contracts only with licensed or permitted out-of-home providers. A child care center provider requesting an initial contract must be licensed or permitted and have a one ~~star~~ plus, two ~~star~~, or three star status before signing Form ~~CCDF 1-E 08CC001E~~. A one star child care home provider requesting an initial contract must be licensed; not on permit, before signing Form ~~CCDF 1-E 08CC001E~~. A child care home provider at one ~~star~~ plus, two ~~star~~, or three star status requesting an initial contract must be licensed or permitted before signing Form ~~CCDF 1-E 08CC001E~~. The procedures in (1) through (8) of this subsection are used to obtain child care contracts.

(1) DCC licensing staff give the child care provider a promotional flyer containing information about contracting with OKDHS. The provider is instructed to contact the

child care liaison for training and review of the contracting requirements.

(2) When contacted by the owner or director of a child care facility, the child care liaison explains that the owner must review the "Contracting with DHS for Child Care Subsidy Payments Handbook" and watch a training video before an initial contract is submitted to the FSSD Child Care Section. In-home child care providers must also watch this training video.

(A) If the owner of a child care center does not live in Oklahoma, the director of the facility can fulfill this requirement.

(B) Child care directors are not required but are highly encouraged to also watch the training video.

(C) The child care liaison arranges an appointment time with the ~~provider~~ owner or director to watch the training video.

(3) If the provider wishes to contract with OKDHS following this training, the child care liaison gives Form ~~CCDF 1-E 08CC001E~~ to the child care provider after typing all identifying information on the contract. The child care liaison explains that the earliest date a contract is valid is the date of approval by the OKDHS Director or designee.

(4) The owner and director sign the contract, ~~have it notarized,~~ before a Notary Public and return the contract to the child care liaison. The owner must also provide proof of his or her identity, a copy of his or her Social Security card, and proof of ownership of the child care business.

(5) The child care liaison ~~attaches~~ sends Form ~~CCDF 1-E, 08CC001E to the FSSD Child Care Section for approval or denial along with:~~

(A) the Contract Routing Checklist;

(B) a copy of the owner's Social Security card;

(C) and proof of ownership; ~~to the Contract Routing Checklist and sends them to the FSSD Child Care Section for approval or denial. If the DCC licensing staff provide the child care liaison with~~

(D) a copy of the provider's Oklahoma State Bureau of Investigation background investigation report; ~~he or she also attaches that document to the contract;~~ and

(E) proof of the employer identification number (EIN) for a child care center provider.

(6) If the child care provider signs Form ~~CCDF 1-E 08CC001E~~ but fails to complete other contracting requirements within 30 calendar days, the child care liaison attaches Form ~~CCDF 1-E 08CC001E~~ to the Contract Routing Checklist and sends it to the FSSD Child Care Section for denial.

(7) If approved, the FSSD Child Care Section staff assign a contract number and send a copy of the signed contract back to the provider.

(8) If denied, the FSSD Child Care Section returns the original contract to the provider with a letter advising the provider OKDHS has decided it is in the best interest of OKDHS not to contract with the provider.

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(c) **Out-of-state providers.** OKDHS does not contract with out-of-state child care providers.

(d) **Changes that must be reported.** Form ~~CCDF-1-E 08CC001E~~ advises child care providers to report to the FSSD Child Care Section the anticipated sale of the business, change of legal business entity, change of location, or plan to stop caring for children no less than 30 calendar days prior to the change occurring. The training video does not need to be viewed as long as the person who signs as owner on the new contract remains the same and he or she already viewed the most recent training video. When the provider fails to report the anticipated change timely and a new contract is needed, a gap may occur in the child care subsidy payment to the provider. A new contract is required in the situations included in (1) through (4).

(1) **Change in facility status.** A change in facility status occurs when a facility changes from a home to a center or a center to a home. A change from a family child care home to a large family child care home does not require a new contract as long as the same license number is used.

(A) When the status of a child care home changes to a child care center, a new license application is required. Prior to signing a new contract, the provider must be issued a license or permit at one ~~star~~ plus, two ~~star~~, or three star status.

(B) When the status of a child care center changes to a child care home, a new license application is required. Prior to signing a new contract, the provider must be issued a license or permit at one ~~star~~ plus, two ~~star~~, or three star status, or be licensed; not permitted, at one star status.

(2) **Change in ownership for a child care center.** The new owner must meet or be anticipated by DCC licensing staff to meet one ~~star~~ plus, two ~~star~~, or three star status within 30 calendar days before a new contract is signed and submitted to the FSSD Child Care Section.

(3) **Change of location.** When a child care center or home provider changes the location of his or her child care business, the provider must sign a new license application ~~and contract~~ agreeing to care for children only in the new location and notify FSSD Child Care Section staff of the new location. The provider's license and contract remain open with the same begin date, the same number assigned, and the star status remains the same.

(4) **Change of legal business entity.** The child care provider must complete a new license application and contract when he or she changes his or her legal business entity. Examples of changing legal business entity include changing from a sole proprietor to a corporation, partnership, or limited liability company. The provider must provide proof of ownership.

(A) A child care center provider who was at one ~~star~~ plus, two ~~star~~, or three star status under their previous legal business entity can sign and submit Form ~~CCDF-1-E 08CC001E~~ to the FSSD Child Care Section while the new license application is pending. A child care center provider who was at one star status under the previous legal business entity cannot sign a

new contract until attaining one ~~star~~ plus, two ~~star~~, or three star status even if a child already receiving child care subsidy benefits is currently in care under their previous legal business entity.

(B) Child care home providers who were at one ~~star~~ plus, two ~~star~~, or three star status under their previous legal business entity can sign and submit Form ~~CCDF-1-E 08CC001E~~ to the FSSD Child Care Section while the new license application is pending. Child care home providers who were at one star status may only sign a new contract once they are licensed; they cannot be ~~on~~ in permit status.

(e) **Providing care at a different site than is authorized.** When the child care provider signs the child care contract, he or she agrees to provide care only at the physical address designated in the contract. In certain circumstances, a child care center provider who owns more than one child care center only may move children eligible for subsidized child care benefits to an alternate center after he or she receives prior approval in writing from the FSSD Child Care Section authorizing him or her to move the children and the point-of-service (POS) machine to the alternate site for a designated period of time. FSSD Child Care Section staff give approval when:

- (1) the same owner or legal business entity owns the alternate site;
- (2) the alternate site is licensed and contracted at the same star level;
- (3) there is a legitimate business reason for providing care in another location; and
- (4) the provider advises FSSD Child Care Section staff how he or she is ensuring that parents are aware their children are being cared for at a difference location.

(f) **Renewal of child care contracts.** Child care provider contracts are effective July 1 through June 30 of each year. Contracts are automatically renewed for successive one year terms, under the same terms and conditions, unless either the provider or OKDHS gives written notice of its intent not to renew to the other party at least 30 calendar days prior to the expiration of the previous term. A contract is not renewed when a provider fails to attend required contract training or to provide any other information or documents requested during the contract renewal period.

(g) **Contract violations.** When the child care provider signs Form ~~CCDF-1-E 08CC001E~~, the provider is agreeing to abide by the terms of the contract. When human services center staff become aware that a provider is violating the terms of the contract, he or she advises the provider to stop the practice immediately and sends an e-mail to FSSD Child Care Section advising of the circumstances. He or she may also complete Form ~~0IG-1 19MP001E~~, Referral Form, to report the violation to the Office of Inspector General. Examples of contract violations include, but are not limited to:

- (1) discriminating against persons seeking services either by charging a discriminatory rate or violating a person's rights as listed in the Civil Rights Act of 1964 as amended, the Rehabilitation Act of 1973 as amended, or the Americans with Disabilities Act of 1990;
- (2) failing to maintain a drug-free workplace;

- (3) possessing or swiping a client's electronic benefit transfer (EBT) card;
- (4) knowing a client's personal identification number (PIN);
- (5) failing to ensure accurate time and attendance information was recorded by the parent or caretaker on the POS machine. The attendance, not time, of a child approved for the part-time or blended unit type must be recorded during the school year by the parent or caretaker;
- (6) charging a client receiving subsidized child care more than the OKDHS rate for days and hours within the client's plan of service;
- (7) charging a client for days and hours outside of client's plan of service or requiring that the client swipe attendance for those days and hours when the additional hours are a requirement of the provider and not a choice of the client;
- (8) moving the children from the agreed upon location shown in the contract for reasons other than field trips and claiming for services at this other location without prior written approval from the FSSD Child Care Section;
- (9) moving the POS machine and allowing parents to record time and attendance at a different location than agreed upon in contract without receiving prior written approval from the FSSD Child Care Section in accordance with subsection (e) of this Section;
- (10) failing to advise and provide OKDHS a completed copy of any agreement the provider enters into within 30 calendar days of entering into such collaboration or agreement. This includes agreements with Head Start, Early Head Start, public schools, and/or any other programs receiving state or federal funding;
- (11) claiming and/or receiving payment from OKDHS for the same hours of care the provider receives payment from another state or federal funding source;
- (12) failing to inform OKDHS of a change in facility status, location, legal business entity, or ownership of the business at least 30 calendar days in advance of the change;
- (13) filing manual claims when they could be filed through the EBT system;
- (14) failing to post all of the facility's rates and fees;
- (15) subcontracting services to another provider without written prior approval from OKDHS;
- (16) refusing unlimited access by a parent or caretaker to the facility during the hours of operation;
- (17) refusing to make available to OKDHS within an hour of request by any OKDHS representative all business records that document proper fiscal and program management by the provider;
- (18) breaching the contract signed by the provider with the OKDHS EBT contractor;
- (19) not maintaining written records for any manual claims filed during the last three years; and
- (20) failing to inform OKDHS in writing within ten calendar days of any person who has an ownership or controlling interest in, or is an agent or managing employee of

the child care business, who has been convicted of a criminal offense related to such person's involvement under Titles XVIII, XIX, or XX of the Social Security Act.

(h) **Cancellation of child care provider contracts.** FSSD Child Care Section staff initiates the cancellation by issuing a notice to the provider by certified mail and regular mail at the same time.

- (1) Contracts may be canceled:
 - (A) with cause. The effective date of cancellation is 13 calendar days after FSSD staff mail the notice. This allows three calendar days for mailing time. The notice must contain a reference to the grounds for cancellation including the specific contract provision(s) that was violated; or
 - (B) without cause. The effective date of cancellation is 33 calendar days after FSSD staff mail the notice. This allows three calendar days for mailing time.
- (2) The FSSD Child Care Section communicates with the child care liaison when a contract is being canceled to ensure that human services center staff have sufficient time to plan with clients to find another facility, if necessary. When it is necessary to cancel authorizations with a child care provider, the provider is notified by use of a computer-generated notice. FSSD Child Care Section staff closes all authorizations with the provider whose contract is canceled.
- (3) When OKDHS initiates contract cancellation, FSSD Child Care Section staff route all correspondence regarding contract cancellation proceedings to:
 - (A) DCC, licensing coordinator;
 - (B) Legal Division;
 - (C) Finance Division;
 - (D) Office of Inspector General;
 - (E) FSSD Overpayment Section;
 - (F) Commodity Distribution Unit;
 - (G) the Child Care Resource and Referral Agency serving the area where the provider is located;
 - (H) Department of Education, Child Care Food Program;
 - (I) Cherokee Nation, if serving the area where the provider is located;
 - (J) Creek Nation, if serving the area where the provider is located;
 - (K) Choctaw Nation, if serving the area where the provider is located;
 - (L) Field Operations Division area office where the provider is located; and
 - (M) the local county director, child care liaison, DCC licensing supervisor, and DCC licensing staff where the provider is located.
- (4) Copies of all correspondence regarding contract cancellation proceedings that are initiated by the provider are routed by the FSSD Child Care Section to:
 - (A) Finance Division; and

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(B) local county director, child care liaison, DCC licensing supervisor, and DCC licensing staff where the provider is located.

[OAR Docket #07-564; filed 3-28-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 50. FOOD STAMP PROGRAM

[OAR Docket #07-565]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 9. Eligibility and Benefit Determination Procedures
340:50-9-5 [AMENDED]
(Reference APA WF 06-19)

AUTHORITY:
Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; and Section 273.11 of Title 7 of the Code of Federal Regulations (CFR).

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Submitted to House:
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Submitted to Senate:
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Gubernatorial approval:
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Legislative approval:
Failure of the Legislature to disapprove the rule(s) resulted in approval on March 28, 2007.

Final adoption:
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Effective:
June 1, 2007

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

ANALYSIS:
Food Stamp Program rule revisions: (1) update language regarding when a benefit reporter case can be reopened; and (2) remove outdated language.

CONTACT PERSON:
Dena Thayer, Programs Manager, Policy Management Unit, OKDHS,
2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-3611.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 1, 2007:

SUBCHAPTER 9. ELIGIBILITY AND BENEFIT DETERMINATION PROCEDURES

340:50-9-5. Changes after application and during the certification period

(a) **Applicant households.** Applicant households must report all changes related to their food stamp benefit eligibility and benefit amount. Households must report changes that occur after the interview but before the date of the notice of eligibility, within ten calendar days of the date of the notice.

(b) **Certified households.** Those households assigned a certification period other than 12 months are required to report within ten calendar days changes in:

- (1) ~~changes in~~ sources of income;
- (2) ~~changes in~~ unearned income of \$50 per month or more;
- (3) ~~changes in~~ earned income of more than \$100 per month;
- (4) ~~all changes in~~ household composition, such as an addition or loss of a household member;
- (5) ~~changes in~~ residence and resulting changes in shelter costs;
- (6) the acquisition of licensed vehicles not fully excluded;
- (7) cash on hand, stocks, bonds, and money in bank checking or savings accounts or savings institutions, when the balance reaches or exceeds a total of \$2,000; and
- (8) ~~changes in~~ the legal obligation to pay child support.

(c) **Change affecting food stamp benefit.** If a reported change affects the household's eligibility or food stamp benefit amount, the household is notified of the adjustment to be made and the effective date. The worker has ten calendar days from the date the change is reported to take the necessary action.

~~(d) **Follow-up.** The household is notified of the receipt of the change report by a computer-generated notice.~~

- (1) If the household fails to report a change within the ten-day period and, as a result, receives benefits to which it is not entitled, an overissuance is referred to the Family Support Services Division, Overpayment Section.
- (2) If the worker fails to take action on a reported change within the prescribed time limits and benefits are lost, they are restored to the household.

(ed) Changes that increase benefits. Changes resulting in a benefit increase must be verified. The household is allowed ten calendar days to verify the information.

- (1) The change is made effective no later than the first issuance to be delivered ten calendar days after the date the change was reported or verified, whichever is later.
- (2) The worker issues a supplement when a change that increases benefits is reported too late to verify and make the change by regular roll deadlines.
- ~~(3) The household is allowed ten calendar days to verify the information.~~

(4) If verification is provided timely, the supplement is issued by the tenth calendar day following the date the change was reported, or the date the regular roll benefit is to be received, whichever is later.

~~(5)~~ If the required verification is not provided within ten calendar days but is provided at a later date, the supplement is issued within ten calendar days of the date

verification was provided, rather than from the date the change was reported.

(fe) **Changes which decrease or terminate benefits.** Food stamp benefits are closed, never suspended, if a change in household circumstances causes a household to be ineligible for food stamp benefits. When a household's benefit level decreases or is terminated, an advance notice is required unless exempt from such a notice for a reason listed in (1) and (2) of this subsection. When an advance notice is required, the decrease or termination of the benefit is effective no later than the month following the month in which the advance notice period expired. When the change is reported less than ten calendar days before the advance notice deadline, the action must be taken before advance notice deadline the following month. Advance notice is not required when:

- (1) the Oklahoma Department of Human Services (OKDHS) receives a clear written statement signed by a responsible household member stating he or she no longer wishes food stamp benefits or giving information which requires termination or reduction of food stamp benefits and stating that he or she understands the food stamp benefit will be reduced or terminated. The household retains its right to a fair hearing and to continue benefits if a fair hearing is requested within ten calendar days of the change notice; and
- (2) the reduction or termination of food stamp benefits is based on situations listed in (j) of this Section.

(gf) **Annual reporting households.** Non-public assistance (non-PA) households with all adult members elderly or disabled with no earned income are known as annual reporters. A 24-month certification period is automatically assigned. These households are required to report within ten calendar days those changes listed in (b) of this Section.

(hg) **Benefit review form for annual reporters.** Annual reporting households are sent computer-generated Form ~~FSS-BR-1~~ 08MP004E, Benefit Review Report, in the 11th month of certification. The intent of this form is to allow the household's circumstances to be reviewed without requiring face-to-face contact.

- (1) The worker must act on any changes reported on Form ~~FSS-BR-1~~ 08MP004E.
- (2) If the reported changes result in a reduction or termination of benefits, an advance notice must be sent to the household.
- (3) If the household fails to provide sufficient information regarding a deductible expense, the benefits are not terminated, but processed without regard to the deduction.
- (4) Form ~~FSS-BR-1~~ 08MP004E must be completed and returned to the ~~county office~~ human services center (HSC), along with all required verification, by the last day of the ~~12th~~ 13th month of certification.

(ih) **Semi-annual reporting households.**

- (1) A 12-month certification period is assigned to non-PA households at certification unless the household contains:
 - (A) a member who is an able-bodied adult without dependents (ABAWD) who is not meeting the work requirement;

- (B) an ABAWD who is not otherwise exempt; or
- (C) all adult household members who are elderly or disabled with no earned income.

(2) These households are only required to report changes that result in their gross monthly income exceeding 130 percent of the monthly poverty income guidelines for their household size. The worker must act on any changes reported by these households that increase their benefits. ~~Changes~~ The worker also acts on changes reported by the household that result in a decrease in benefits ~~are also acted upon by the worker~~. The system determines if the change results in a decrease in benefits. A decrease in benefits does not occur unless the:

- (A) household has requested closure of the case; or
- (B) worker has information about the household's circumstances considered verified upon receipt.

(ji) **Benefit review form for semi-annual reporters.** Semi-annual reporting households are sent a computer-generated Form ~~FSS-BR-1~~, ~~Benefit Review Report~~, 08MP004E in the fifth month of certification.

- (1) The worker must act on any changes reported on Form ~~FSS-BR-1~~ 08MP004E.
- (2) If the reported changes result in a reduction or termination of benefits, an advance notice must be sent to the household.
- (3) If the household fails to provide sufficient information regarding a deductible expense, the benefits must not be terminated, but processed without regard to the deduction.
- (4) Form ~~FSS-BR-1~~ 08MP004E must be completed and returned to the ~~county office~~ HSC, along with all required verification, by the last day of the ~~sixth~~ seventh month of certification.

(kj) **Notice of adverse action not required.**

- (1) **Mass changes.** The individual notification requirement is waived when changes affecting the entire caseload or significant portions of the caseload are initiated because of changes or requirements in federal or state law. In these situations, the Family Support Services Division (FSSD) mails notices to the households informing them of the changes that are about to be made.
- (2) **Notice of death.** If the worker determines, based on reliable information, that all members of the household are deceased, notice of adverse action is not required.
- (3) **Moved out of county.** Notice of adverse action is not required when the worker determines, based on reliable information, that the household has moved out of the county and that a transfer request has not been received.
- (4) **Completion of restoration of lost benefits.** Notice of adverse action is not required if the household is previously notified in writing when restoration of lost benefits is completed and the household's food stamp benefit is reduced due to completion of restoration of lost benefits.
- (5) **Variable food stamp benefit.** The household benefit amount varies from month to month within the certification period to take into account changes that were anticipated at the time of certification and the household was so notified at the time of certification.

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(6) **Willful misrepresentation.** Notice of adverse action is not required if a person in the household is disqualified for willful misrepresentation. If there is more than one person in the household, the benefits of the remaining household members are reduced or terminated to reflect the disqualification of that household member.

(7) **Food stamp benefit recoupment.** A notice of adverse action is not required if the household fails to make agreed upon cash or food stamp benefit repayment of an overpayment.

(8) **Drug or alcohol treatment center or group home loses approved status.** If a household's eligibility is being terminated because the drug or alcohol treatment center or group home facility is no longer approved, an individual notice of adverse action is not required.

(H) **Action on changes when fair hearings are requested.** When a household requests a fair hearing within ten calendar days of the date shown on the adverse action notice, the household may continue to receive food stamp benefits.

[OAR Docket #07-565; filed 3-28-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 65. PUBLIC ASSISTANCE PROCEDURES

[OAR Docket #07-566]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Eligibility for Benefits
340:65-3-4 [AMENDED]
340:65-3-8 [AMENDED]
Subchapter 5. Procedures Relating to Case Changes
Part 1. General Provisions
340:65-5-6 [AMENDED]
(Reference APA WF 06-16)

AUTHORITY:
Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; and Sections 161 et seq. of Title 56 of the Oklahoma Statutes.

DATES:
Comment period:
December 15, 2006 through January 16, 2007

Public hearing:
None requested

Adoption:
January 23, 2007

Submitted to Governor:
January 23, 2007

Submitted to House:
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Gubernatorial approval:
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Legislative approval:
Failure of the Legislature to disapprove the rule(s) resulted in approval on March 28, 2007.

Final adoption:
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Effective:
June 1, 2007

SUPERSEDED EMERGENCY ACTIONS:

n/a
INCORPORATIONS BY REFERENCE:
n/a

ANALYSIS:
Chapter 65 rule revisions: (1) add information regarding when six month Temporary Assistance For Needy Families (TANF) reviews are needed; (2) change information regarding benefit reporter households; (3) clarify existing rules; (4) replace obsolete language; and (5) reflect current form numbers.

CONTACT PERSON:
Dena Thayer, Programs Manager, Policy Management Unit, OKDHS, 2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-3611.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 1, 2007:

SUBCHAPTER 3. ELIGIBILITY FOR BENEFITS

340:65-3-4. Investigation of eligibility conditions and services planning

Worker responsibility. The worker is responsible for collecting information necessary for determining the client's eligibility for benefits and ensuring all of the client's social services needs are addressed and met. When verification of information from a source other than the client's statement is necessary, the sources described in this Section are used.

(1) **Home visits.** Home visits are necessary for Field Operations Division (FOD), Family Support Services staff to provide services and benefits and to promote safety and stability for families. All home visits must be planned and coordinated to prevent duplication of efforts.

(A) FOD, Adult Protective Services staff may make home visits and client contacts outside normal working hours within policy as outlined in OAC 340:5.

(B) Workers may make home visits or other client contacts outside normal working hours when it is in the best interest of the client and approved by appropriate supervisory personnel. If it is necessary for a worker to have contact with a client outside of normal working hours because of an emergency and the worker's immediate supervisor is not available, authorization must be obtained from the county director or designee prior to the contact. If the immediate supervisor and county director or designee are not available, the worker takes care of the client's emergency need and notifies appropriate supervisory personnel of the situation immediately after returning to duty.

(C) Home visits are made when:

- (i) there is a need to confirm the accuracy of statements and documentation cannot be obtained from other sources;
- (ii) an office visit would create a hardship on the household;

- (iii) a Temporary Assistance for Needy Families (TANF) case is closed due to failure to cooperate according to OAC 340:10-2-2;
- (iv) it is the best method to complete or review the employability plan;
- (v) protective services are needed; or
- (vi) the worker deems it necessary.

(2) **Collateral sources.** The client's signature on the application for assistance is the necessary authorization for securing required information or verification from collateral sources. If the collateral source requires written authorization before supplying information to the Oklahoma Department of Human Services (OKDHS), Form ~~ADM-60-08AD060E~~, Request for Release of Information, is completed. This authorization includes the permission of the client's spouse for information regarding his or her circumstances to be given in connection with the same application, and of the client's parents when the client is a dependent child who is blind or disabled. The worker is responsible for discussing with the client any inconsistent information obtained from collateral sources related to the client's eligibility.

(A) Persons who are contacted for information related to the client's eligibility are advised of how the information is used and the reason it is needed. If the person is unwilling for the client to know his or her identity, the person's name is not recorded in the case record and is not revealed to the client.

(B) ~~The names of persons who contact someone contacts~~ When someone contacts OKDHS with information related to the client's eligibility ~~are and requests anonymity, that person's name is~~ not recorded in the case record nor revealed to the client ~~when anonymity is requested.~~

(3) **Public records.** Sources of information in the form of public records that provide essential information may be obtained without consent from any individual whose transactions are involved.

(4) **Data exchange.** Automated data exchange with other agencies provides benefit, wage, and tax information that is matched with OKDHS records. The worker is responsible for:

(A) reviewing data exchange information at the time of application and ~~redetermination~~ review of eligibility. Data exchange information screens available are:

- (i) Beneficiary and Earnings Data Exchange System (BENDEX);
- (ii) Buy-In Data Exchange (BIL);
- (iii) SSI/State Data Exchange System (SDX);
- (iv) SSA Beneficiary Earnings Exchange Record (BEER/BWG);
- (v) New Hire Employee list (NHL);
- (vi) Social Security Number (SSN) Verification - SSN Enumeration;
- (vii) Wage Data Exchange;
- (viii) Unemployment compensation; and
- (ix) Unearned income report (IEVS-IRS);

- (B) initiating appropriate queries; and
- (C) resolving data exchange discrepancy messages within 30 days of the date the message is posted on the data exchange inquiry screen.

(5) **Systematic Alien Verification for Entitlement (SAVE).** All applicants and recipients of the TANF, Medicaid, Food Stamp Program, and Child Care ~~Services Program~~ benefits are required to declare their citizenship status. Persons who declare themselves or their minor child(ren) non-citizens must present documentation of their legal alien status from the United States Citizenship and Immigration Services (USCIS) or other acceptable resource. The status, as determined from the documentation, must be verified through the Alien Status Verification Index (ASVI) maintained by USCIS.

(6) **Workers' compensation.** Family Support Services Division (FSSD) reviews copies of all Workers' Compensation Court documents by matching SSNs with OKDHS records. Any court action that appears to potentially impact eligibility is forwarded to the servicing ~~county~~ human services center (HSC) office for clearance. A copy of the document is retained in the case record.

(7) **Vital records verification.** Verification of birth records, when not otherwise available, for persons born in Oklahoma may be secured by sending a completed Form ~~ADM-64-08AD064E~~, Division of Vital Records, in duplicate to FSSD Overpayments Section. Form ~~ADM-64-08AD064E~~ must be retained in OKDHS case files only and not copied for any individual or agency, in accordance with the agreement between OKDHS and the Oklahoma State Department of Health.

(8) **Food stamp disqualification (FSD).** The FSD transaction is used to determine if a client has been disqualified from the Food Stamp Program due to fraud. If a client has been disqualified, the FSD screen shows the date the disqualification began and the length of the disqualification period.

340:65-3-8. Determination of continuing eligibility

Eligibility determination is a continuing process which must be carried out at appropriate intervals. The appropriate interval for ~~redetermining~~ or reviewing eligibility depends on the type(s) of benefit(s) received. An eligibility ~~redetermination~~ or review may be scheduled to synchronize with other benefit reviews or redeterminations. The ~~social services specialist~~ worker is responsible for:

- (1) advising the recipient at each contact of the recipient's responsibility to report changes within ten calendar days of the date the change becomes known;
- (2) making contacts at unspecified intervals to ensure continuing eligibility; and
- (3) determining continuing eligibility.

(A) A periodic ~~redetermination~~ review of eligibility is completed at 12-month intervals for:

- (i) a Temporary Assistance for Needy Families (TANF) recipient except when six-month intervals are required due to:
 - (I) protective payments;

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- (II) pending required immunizations;
 - (III) payment standard reductions due to intentional program violations; ~~or~~
 - (IV) hardship extension approvals;
 - (V) earned income;
 - (VI) work-eligible individual exempt from TANF Work activities due to incapacity; or
 - (VII) work-eligible individual exempt from TANF Work activities due to caring for an disabled family member living in the household;
- (ii) a State Supplemental Payment (SSP) recipient based on the ~~redetermination~~ review of need for Health Benefits;
 - (iii) a child in state or tribal custody;
 - (iv) child care ~~services~~ benefits except when:
 - (I) there is an expected or reported change in the days and hours child care is needed;
 - (II) there is an anticipated change in income; or
 - (III) protective or preventive child care is approved;
 - (v) a non-public assistance (non-PA) food ~~stamp benefit~~ household ~~that has earned income~~, unless the household contains an able-bodied adult without dependents who is not meeting work requirements or is not otherwise exempt, or all adult household members are elderly or disabled with no earned income. A benefit review is completed at six-month intervals by sending Form ~~FSS BR 1 08MP004E~~, Benefit Review Report, to the household in the fifth month of certification; and
 - (vi) ~~certain non-PA Health Benefits recipients, excluding recipients who are approved for nursing care or alternative care services except those who are approved for less than 12 months~~. A benefit review is completed at ~~six~~ 12-month intervals by sending Form ~~FSS BR 1 08MP004E~~, to the recipient in the ~~fifth~~ 11th month of certification.
- (B) A periodic ~~redetermination~~ review of eligibility is completed at 24-month intervals for a non-PA food ~~stamp benefit~~ household with all adult members elderly or disabled with no earned income. A benefit review is completed at 12-month intervals by sending Form ~~FSS BR 1 08MP004E~~ to the household in the 11th month of certification.

for which the client was later determined eligible, or an overpayment of benefits the client was not eligible to receive. A reconsideration of the administrative action is required when:

- (1) computer down time prevents action being taken timely;
 - (2) policy and procedures were not administered correctly; or
 - (3) new or additional information is received within 30 calendar days of the:
 - (A) date action was taken to deny the application; or
 - (B) effective date benefits were terminated.
- (b) A retroactive payment is authorized to correct an administrative action which resulted in a payment being discontinued, an application denied, or an underpayment.
- (1) **Payments discontinued for Temporary Assistance for Needy Families (TANF) and State Supplemental Payment (SSP).** When the ~~county office~~ local human services center (HSC) reconsiders its previous action and finds the payment was discontinued in error, a payment is made for the current month and prior months, provided the amount authorized was improperly discontinued in these months and does not exceed the standard on ~~DHS Oklahoma Department of Human Services (OKDHS) Appendix C-1, Schedule of Maximum Income, Resource, and Payment Standards.~~
 - (2) **Application denied for TANF and SSP.** When an application is denied and ~~the county office~~ local HSC staff subsequently reconsiders its previous action and finds the applicant is eligible, a benefit is issued for whatever period the client is determined eligible but no earlier than the date of application.
 - (3) **Underpayments determined for TANF and SSP.** When a benefit was issued for less than the amount for which the client was eligible, the worker authorizes an underpayment ~~is authorized by Form F 17, Terminal Disposition and Issuance~~, for whatever period of time that underpayment was made.

[OAR Docket #07-566; filed 3-28-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 75. CHILD WELFARE

[OAR Docket #07-642]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:

- Subchapter 1. General Provisions of Child Welfare Services
 - Part 1. Scope and Applicability
 - 340:75-1-12.2 [AMENDED]
 - 340:75-1-18 through 340:75-1-18.1 [AMENDED]
 - Part 3. Child Welfare Confidentiality
 - 340:75-1-44 [AMENDED]
- Subchapter 4. Family-Centered and Community Services
 - Part 1. Voluntary Family-Centered Services
 - 340:75-4-12.1 through 340:75-1-12.2 [AMENDED]
 - 340:75-4-13 [AMENDED]
 - Subchapter 6. Permanency Planning

SUBCHAPTER 5. PROCEDURES RELATING TO CASE CHANGES

PART 1. GENERAL PROVISIONS

340:65-5-6. Reconsideration of administrative action

- (a) Corrective action is required on any administrative action which results in withholding of benefits, an underpayment

Part 5. Permanency Planning Services
 340:75-6-31 [AMENDED]
 340:75-6-31.5 [AMENDED]
 Part 7. Case Plans
 340:75-6-40.2 through 340:75-6-40.5 [AMENDED]
 Part 8. Role of the Child Welfare Worker
 340:75-6-48 [AMENDED]
 Part 11. Permanency Planning and Placement Services
 340:75-6-85 [AMENDED]
 340:75-6-85.2 [AMENDED]
 340:75-6-85.4 through 340:75-6-85.6 [AMENDED]
 340:75-6-86 [AMENDED]
 340:75-6-88 through 340:75-6-89 [AMENDED]
 Subchapter 8. Therapeutic Foster Care and Developmental Disabilities Services
 Part 1. Therapeutic Foster Care
 340:75-8-1 [AMENDED]
 340:75-8-6 through 340:75-8-11 [AMENDED]
 Part 3. DDS Services for Children in Custody Children
 340:75-8-36 through 340:75-8-39 [AMENDED]
 Subchapter 15. Adoptions
 Part 14. Post Adoption Services
 340:75-15-128.1 through 340:75-15-128.3 [AMENDED]
 340:75-15-128.5 through 340:75-15-128.6 [AMENDED]
 Subchapter 16. Mental Health Treatment Services
 Part 1. Inpatient Mental Health Treatment
 340:75-16-29 through 340:75-16-32 [AMENDED]
 340:75-16-34 through 340:75-16-37 [AMENDED]
 Part 3. Outpatient Behavioral Health Care Services
 340:75-16-45 [AMENDED]
 Subchapter 19. Working with Indian Children
 340:75-19-1. through 340:75-19-4 [AMENDED]
 340:75-19-11 [AMENDED]
 340:75-19-16 [AMENDED]
 340:75-19-22 [AMENDED]
 340:75-19-26 [AMENDED]
 340:75-19-28 through 340:75-19-31 [AMENDED]
 340:75-19-33 [AMENDED]

(Reference APA WF 06-09 and 06-23)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2, 3 and 4 of the Oklahoma Constitution; House Bill (HB) 2840, the Kelsey Smith-Briggs Child Protection Reform Act; HB 2656; House Resolution 5403; Public Law 109-239; Sections (§§) 7001-1.1 et seq. of Title 10 of the Oklahoma Statutes (O.S.), the Oklahoma Children's Code; 10 O.S. §§ 7003-6.2, 7003-6.2A, 7005-1.4, 7106(K), and 7510-1.1 et seq., the Oklahoma Adoption Assistance Act; and 74 O.S. 150.5(A)(1)(e).

DATES:

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None requested.

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 15. Adoptions
 Part 14. Post adoption services
 340:75-15-128.1 [AMENDED]

(Reference APA WF 06-09)

Gubernatorial approval:

October 31, 2006

Register publication:

24 Ok Reg 210

Docket number:

06-1400

ANALYSIS:

The proposed revisions to Subchapters 1, 4, 6, 8, 15, 16, and 19 of Chapter 75 clarify: (1) the appeal process in cases of child abuse or neglect; (2) Oklahoma Department of Human Services (OKDHS) requirements for confidentiality and disclosure of information without a court order; (3) reasonable efforts are made in permanency planning to consider in-state and out-of-state placements; (4) options available for voluntary family-centered services; (5) procedures, terminology, and responsibilities regarding permanency placement; (6) the CW worker's role when a child in OKDHS custody is receiving Developmental Disability Services Division (DDSD) services; (7) contact frequency between CW worker and child and CW worker and parent; (8) that the court may not direct placement of a child who is placed in OKDHS custody; (9) a child may travel outside the country with the placement provider or person approved by the child's CW worker, and with judicial approval; (10) requirement for therapeutic foster care child care and respite providers; (11) requirements for DDSD needs assessment and referrals; (12) age and exceptions for termination of adoption assistance payments; (13) eligibility for Title IV-E adoption assistance; (14) that APS Healthcare is designated by Oklahoma Health Care Authority to facilitate outpatient and inpatient psychiatric medical necessity care reviews for acute and residential inpatient mental health treatment; (15) the reviewer's decision-making process for length of stay and extension of stay in an inpatient mental health facility; (16) protocol when a child no longer meets medical necessity criteria for inpatient treatment; (17) the criteria for acute medical necessity; (18) the applicability of the Federal and Oklahoma Indian Child Welfare Acts (ICWA) in child custody proceedings that involve adoptive placement of an Indian child; and (19) protocol for placement of an Indian child in voluntary foster care; and (20) ensure that rule procedures are consistently implemented by updating language and form numbers to conform to current usage and comply with federal, state, and OKDHS standards.

CONTACT PERSON:

Dena Thayer, Programs Manager, Policy Management Unit, DHS, 2400 N. Lincoln Blvd., Oklahoma City, OK 73105, 405-521-4326.

DUE TO EXCESSIVE LENGTH OF THESE RULES (AS DEFINED IN OAC 655:10-7-12), THE FULL TEXT OF THESE RULES WILL NOT BE PUBLISHED. THE RULES ARE AVAILABLE FOR PUBLIC INSPECTION AT THE DEPARTMENT OF HUMAN SERVICES, SEQUOYAH BUILDING, OKLAHOMA CITY AND AT THE SECRETARY OF STATE'S OFFICE OF ADMINISTRATIVE RULES. THE FOLLOWING SUMMARY HAS BEEN PREPARED PURSUANT TO 75 O.S., SECTION 255(B):

SUMMARY:

340:75-1-12.2 is amended to update form numbers and clarify procedures.
 340:75-1-18 is amended to clarify that the court makes a determination whether reasonable efforts have been taken to finalize the permanent placement of the child, if appropriate, through interstate placement.
 340:75-1-18.1 is amended to update form numbers.
 340:75-1-44 is amended to: (1) update agency names and form titles; (2) clarify that when a person responsible for a child is criminally charged, OKDHS may release to the public specific recommendations made to the district attorney and specific recommendations made by OKDHS in any progress reports submitted to the court, including recommendations made at the hearing as they relate to the custody or placement of the child; (2) clarify that disclosure of juvenile court records about the child, without a court order, to parent, legal guardian, or custodian, are withheld from the parent only when a court order is in effect that prohibits the parent from obtaining information and that if a child is removed from the home, the parent is informed of the child's general location, but not the specific address unless the foster parent consents to disclosure as part of the family reunification effort; and (4) details the procedures for limited disclosure of court records, including that OKDHS does not disclose the identity or location of any person who has reported child abuse or neglect, unless specifically ordered by the court.
 340:75-4-12.1 is amended to: (1) list options for services for voluntary family-centered services; (2) update form numbers; (3) clarify procedures for signing Form 04FC007E, Authorization from Parent or Guardian for Voluntary

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Foster Family Home Placement and Medical Care of Child prior to placement of child; and (4) move SoonerStart services referral procedure to this Section.

340:75-4-12.2 is amended to: (1) delete language that was moved to another section; and (2) clarify criteria used in determining referrals for services.

340:75-4-13 is amended to update form numbers and delete obsolete language.

340:75-6-31, 31.5, 40.3, 40.5, 85.2, 85.4, 85.5, 86, and 88 are amended to: (1) update agency names, position titles, form numbers, and terminology; and (2) clarify procedures.

340:75-6-40.2 and 340:75-6-40.4 are amended to: (1) update procedures and form numbers; and (2) add language that conforms to the Safe and Timely Interstate Placement of Foster Children Act of 2006, Public Law 109-239, clarifying that courts are required to consider in-state and out-of-state placement options in permanency hearings.

340:75-6-48 is amended to: (1) provide that Child Welfare (CW) contact with a child in the custody of the parent in a supervision only case occurs with no more than 31 days between contacts; (2) clarify the CW worker role when a child in OKDHS custody is receiving DDS services; (3) update form numbers; and (4) provide exceptions to, and direction for, contact with the parent when the child has been returned to or has never been removed from the parent's custody and OKDHS has been ordered to provide supervision.

340:75-6-85 is amended to: (1) provide that if the court determines it would be in the best interests of the child, the court may place the child in the legal custody of OKDHS. If the child is placed in the custody of OKDHS, the court may not direct OKDHS to place the child in a specific home or placement; and (2) update form numbers.

340:75-6-85.6 is amended to provide direction for voluntary placement of a child born to a youth who is in OKDHS custody.

340:75-6-89 is amended to: (1) update terminology; and (2) clarify that a child in custody may travel outside the country.

340:75-8-1, 6, 7, 10, 11, 39 are amended to: (1) update agency names, form numbers, terminology, and citations of rules and statutes; and (2) clarify procedures.

340:75-8-8 is amended to: (1) update terminology and clarify procedures; and (2) include the requirement that the written request from therapeutic foster care (TFC) contractors for child care must include verification of child care licensing status or TFC approval as a respite provider when an individual is the child care provider.

340:75-8-9 is amended to: (1) reflect current procedures; and (2) include the requirement that TFC contractors include in the written request, prior to the placement of a child five years of age or younger, a description of the proposed TFC parent's parenting responsibilities to other children in the home, children in foster care or therapeutic foster care placement, any adopted children, and any birth children of the TFC parent.

340:75-8 Part 3 tagline is amended to reflect current OKDHS language usage.

340:75-8-36 is amended to: (1) update form numbers; and (2) require that DDS area staff provide a copy of the written needs assessment to CW staff and work with CW staff to identify referrals and needed resources.

340:75-8-37 is amended to clarify CW county of jurisdiction worker responsibilities for a child receiving home and community-based waiver services.

340:75-8-38 is amended to update language for clarity and conciseness.

340:75-8-39 is amended to clarify the CW worker's responsibility in assisting the potential guardian to petition for guardianship 30 days prior to the child's 18th birthday.

340:75-15-128.1 is amended and supersedes the emergency revisions to comply with statutory amendments reflecting that adoption assistance payments are not made to parents of a child who is 18 years old, except the child may continue to receive assistance until the child is 19 years old if the child continues to attend high school or pursues General Educational Development, or meets the criteria for an adoption assistance difficulty of care payment as determined by OKDHS.

340:75-15-128.2 is amended to clarify eligibility for Title IV-E adoption assistance.

340:75-15-128.3 is amended to update form numbers and terminology.

340:75-15-128.5 amended to: (1) update form numbers; and (2) clarify the adoption assistance annual review process.

340:75-15-128.6 is amended to update form numbers, language, and rule citations.

340:75-16-29 and 30 are amended to reflect APS Healthcare as the new entity designated by Oklahoma Health Care Authority to facilitate outpatient

and inpatient psychiatric medical necessity care reviews for acute and residential inpatient mental health treatment.

340:75-16-31 and 36 are amended to update agency names, position titles, form numbers, and procedures.

340:75-16-32 is amended to clarify the decision-making process for length of stay in an inpatient mental health facility and extension by the APS Healthcare inpatient reviewer.

340:75-16-34 is amended to clarify: (1) CW contact requirements; and (2) hearing time frames.

340:75-16-35 is amended to clarify inpatient mental health treatment facility liaison duties.

340:75-16-37 is amended to specify that the child is discharged and placed in an appropriate placement when the child no longer meets medical necessity criteria for inpatient treatment, and the therapist and physician agree to discharge.

340:75-16-45 is amended to designate APS Healthcare as the medical necessity reviewer for behavioral health services.

340:75-19-1, 2, 11, 16, 22, 26, 28, 30, 31, and 33 are amended to update and clarify agency names, position titles, form numbers, terminology, definitions, and procedures; and delete obsolete language.

340:75-19-3 is amended to update: (1) the definition of adoptive placement and foster care placement to correspond with language in the Federal ICWA; and (2) terminology to reflect current OKDHS usage.

340:75-19-4 is amended to: (1) correspond with language in the Federal ICWA and clarify that the Federal and Oklahoma ICWA are applicable to any child custody proceeding that involves adoptive placement, including permanent placement of an Indian child for adoption, and including any action resulting in a final decree of adoption; and (2) update terminology to reflect current OKDHS usage.

340:75-19-29 is amended to: (1) add that the tribal CW worker or OKDHS CW worker advises the parent or guardian at the time of the child's placement that any evidence gathered during the time the child is in voluntary foster care may be used as a basis for court action; (2) clarify that when the tribal CW worker places the child in voluntary foster care, the tribe is responsible for obtaining a written voluntary foster care agreement that gives authority to the child's tribe to place the child in foster family care and provide for the child's needs; (3) clarify that the agreement does not require court action, and the child is returned to the parent or guardian upon request. If the parent or guardian fails to meet the terms of the agreement or cannot be located, court involvement is required; and (4) update terminology to reflect current OKDHS usage.

[OAR Docket #07-642; filed 4-3-07]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES DIVISION

[OAR Docket #07-567]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

340:100-1-2 [AMENDED]

Subchapter 3. Administration

Part 1. General Administration

340:100-3-1.1 [REVOKED]

340:100-3-5 through 340:100-3-5.2 [AMENDED]

Part 3. Operations

340:100-3-33.2 [NEW]

340:100-3-34 [AMENDED]

340:100-3-37 [REVOKED]

340:100-3-39 [AMENDED]

Subchapter 5. Client Services

Part 3. Service Provisions

340:100-5-15 [AMENDED]

340:100-5-19 [REVOKED]

340:100-5-22.6 [AMENDED]

Subchapter 6. Group Home Regulations

Part 1. General Provisions

340:100-6-1 [REVOKED]
 340:100-6-2 [AMENDED]
 Part 3. ~~Basic Licensure~~ Standards
 340:100-6-10 through 340:100-6-15 [AMENDED]
 340:100-6-16 through 340:100-6-17 [REVOKED]
 340:100-6-18 through 340:100-6-21 [AMENDED]
 Part 5. ~~Construction Requirements And~~ Physical Plant Requirements
 340:100-6-30 [AMENDED]
 340:100-6-31 through 340:100-6-35 [REVOKED]
 Part 7. Environmental Health, Safety, and ~~Sanitary Sanitation~~
 Requirements
 340:100-6-40 [REVOKED]
 340:100-6-41 [AMENDED]
 340:100-6-42 through 340:100-6-43 [REVOKED]
 340:100-6-44 [AMENDED]
 340:100-6-45 [NEW]
 Part 9. Dietary Requirements
 340:100-6-50 [AMENDED]
 Part 11. Program Standards
 340:100-6-55 [AMENDED]
 340:100-6-56 [NEW]
 Part 13. Individual ~~Habilitation~~ Plan, Training, and Services
 340:100-6-60 [AMENDED]
 340:100-6-61 through 340:100-6-62 [REVOKED]
 Part 15. Medication Storage and Administration. [REVOKED]
 340:100-6-70 [REVOKED]
 Part 17. Residents' Funds. [REVOKED]
 340:100-6-75 [REVOKED]
 340:100-6-76 [REVOKED]
 Part 19. Involuntary Transfer or Discharge of ~~Resident~~ Service Recipient
 340:100-6-85 through 340:100-6-86 [AMENDED]
 340:100-6-87 [REVOKED]
 340:100-6-88 [AMENDED]
 Part 21. ~~Resident's~~ Resident Rights and Responsibilities
 340:100-6-95 [AMENDED]
 340:100-6-96 [REVOKED]
 340:100-6-97 [AMENDED]
 340:100-6-98 [REVOKED]
 Subchapter 17. Employment Services
 Part 5. Other State Funded ~~Vocational~~ Employment Services
 340:100-17-30 [AMENDED]
(Reference APA WF 06-13)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2, 3, and 4 of the Oklahoma Constitution; and, in part, 10 O.S. § 1430.1 et seq., Group Homes for Persons with Developmental or Physical Disabilities Act, as amended by House Bill (HB) 2592; 22 O.S. § 1175.6b; Articles I, II, III, and IV of 30 O.S.; 43A § 10-103; 56 O.S. § 1020 and 1025.1 through 1025.3; and 60 O.S. § 863.

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INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Revisions to Subchapters 1, 3, 5, 6 and 17 of Chapter 100, Title 340: (1) reflect current terms and definitions used throughout Developmental Disabilities Services Division (DDSD) rules; (2) specify provisions of Home and Community-Based Services (HCBS) Waiver services by legally responsible persons and others; (3) amend procedures for reporting incidents involving service recipients; (4) specify current pre-employment screening procedures; (5) reflect current DDSD case manager activities; (6) specify staffing requirements for alternative group homes; (7) amend group home requirements necessary to comport with HB 2592, effective November 1, 2006; (8) organize existing group home requirements in topical sequence; (9) delineate state funded employment services; and (10) revoke rules that are duplicative or incorporated into other Sections.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

340:100-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Active treatment" means aggressive and consistent implementation of a program of specialized and generic training, treatment, and health services ~~that is~~ directed toward the service recipient's acquisition ~~by the individual~~ of skills necessary to function as independently as possible.

"Adaptive equipment services" means activities ~~that assess the need for and acquisition of equipment or products which may be customized to increase, maintain, or improve the functional capabilities of individuals with developmental disabilities. These services include consumer and provider training in the use and maintenance of equipment, as well as equipment repair. Equipment provided through this service includes:~~

- ~~(A) mobility and positioning devices such as wheelchairs, travel chairs, walkers, positioning systems, ramps, wheelchair lifts, bath seats, bath lifts, specialized beds, corner chairs, or feeder chairs;~~
- ~~(B) orthotic and prosthetic devices such as braces and prescribed modified shoes;~~
- ~~(C) augmentative or alternative communication aids such as language boards, or electronic communication aids; and~~
- ~~(D) environmental controls such as devices to turn on and off appliances, use a telephone, or open doors.~~

"Advisory Committee on Services to Persons with Developmental Disabilities" means the committee appointed by the Director of ~~the~~ Oklahoma Department of Human Services (OKDHS) ~~which has a legislative mandate~~ to review and make recommendations on rules and programs of ~~the~~ Developmental Disabilities Services Division (DDSD) to the Director and ~~the~~ Oklahoma Commission for Human Services.

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"Advocate" means a person who speaks for or on behalf of an individual a service recipient, especially when individual rights or interests are at risk.

"Age appropriate" means that aspect of normalization that reinforces recognition of an individual as a person of his or her chronological age.

"Alternative appropriate setting" means a residential setting, other than a nursing facility, in which needed habilitation services are provided. ~~In most cases, including an alternative appropriate setting is accessed through waived services the individual is determined eligible to receive commensurate with the eligibility requirements of this Chapter intermediate care facility for the mentally retarded (ICF/MR) or Home and Community-Based Services (HCBS).~~

"Architectural modification services" means activities that assess the need for and provide alterations to a residence of an service recipient, to ensure safety, security, and accessibility. Modifications include:

- (A) ramps;
- (B) lifts such as porch, chair, and hydraulic lifts;
- (C) bathroom facilities such as roll in showers, sink and bathtub modifications, toilet, floor urinal, and bidet adaptations, water faucet controls, plumbing modifications, and turnaround space;
- (D) kitchen facilities such as sink modifications, sink cutouts, turnaround space, water faucet controls, plumbing modifications, work surface, and cabinetry adjustments; and
- (E) specialized accessibility adaptations such as door widening, electrical wiring modifications, grab bars and handrails, automatic door openers, door bells, voice activated, light activated, and electronic devices.

"Assessment" means the process of identifying:

- (A) ~~an individual's a service recipient's:~~
 - (i) present developmental or functional level;
 - (ii) ~~and health status;~~
 - (iii) ~~the individual's developmental strengths and needs;~~ and
 - (iv) ~~the environment;~~ and
- (B) other conditions that support or impede the service recipient's development.

~~**"Audiological examination and treatment services"** means activities performed by an audiologist licensed by the State Board of Examiners for Speech Language Pathology and Audiology which may include treatment and counseling regarding the use and care of individual hearing aids.~~

"Capacity to give informed consent" means the ability to make and express voluntary decisions, given correct and sufficient information about the nature, purpose, risks, and benefits of a proposed service or action, and has not been adjudicated incapacitated by a court for purposes of the decision.

"Case manager" means a professional who is responsible for assuring that ensuring services to an individual a service recipient are planned and provided in a coordinated fashion. Additional responsibilities include through independent advocacy, brokerage, and monitoring activities with, and on behalf of, service recipients.

"Challenging behavior" means a behavior ~~which that~~, by its frequency or degree of intensity:

- (A) places at risk ~~an individual's a service recipient's~~ physical safety, environment, relationships, or participation in the community; or
- (B) creates a risk of involvement in civil or criminal processes.

"Client Contact Manager (CCM)" means a computer software system used by DDS case managers to collect and monitor case management data for all service recipients.

"Community Integrated Employment (CIE)" means a service program ~~which that~~ provides placement, job training, and short-term or long-term supports to assist service recipients in achieving and maintaining employment within the community.

~~**"Companion services"** means living arrangements in which a service recipient shares a home with a non disabled person who may or may not be a paid provider of services to the service recipient.~~

"Confidential information" means:

- (A) information related to a service recipient generated by OKDHS or contract providers; and
- (B) observations of and discussions concerning ~~the condition~~ of service recipients, their families, guardians, or friends.

"Consumer" means a person who is a direct recipient or beneficiary of service planning and delivery. ~~"Consumer" and is synonymous with "client," "service recipient," and "individual served."~~

"Contract provider or agency" means an agency or individual person rendering services to persons with developmental disabilities under a contractual agreement with OKDHS or Oklahoma Health Care Authority (OHCA).

"Convalescent care" means nursing facility care:

- (A) following a person's release from an acute care hospital that is part of a medically prescribed period of recovery; and
- (B) ~~Convalescent care that~~ is not expected to exceed an established number of days.

"DDSD" means ~~the~~ Developmental Disabilities Services Division, an operating unit of OKDHS.

"Deaf" means ~~hearing loss so severe that the individual cannot communicate through oral or aural means.~~

"Dementia" means a degenerative disease of the central nervous system as diagnosed by a physician in accordance with the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

"Demonstrated need" means critical elements required by service recipients to prepare for or continue to lead a full and productive life in the community, which can be authorized by the DDS case manager, in accordance with this Chapter. Needs are distinguished from wants which include things that would be nice to have. Funding for a person's wants comes from the person's own resources, natural supports, or community resources.

~~**"Dental examination and prophylaxis"** means activities of a licensed dentist that diagnose acute or chronic dental conditions, support oral hygiene through medically indicated~~

cleansing and scale removal procedures, and prescribe training procedures promoting independence in oral hygiene for service recipients.

"Developmental disability" means a severe chronic disability of a person ~~which that~~:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the person attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the areas of major life activity ~~which that~~ are:

- (i) self-care;
- (ii) receptive and expressive language;
- (iii) learning;
- (iv) mobility;
- (v) self-direction;
- (vi) capacity for independent living; and
- (vii) economic self-sufficiency; and

(E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services ~~which that~~ are of lifelong or extended duration and are individually planned and coordinated.

"DHS" means the Oklahoma Department of Human Services (OKDHS).

"Family counseling" means activities to identify stresses within a family group and to develop the skills within the family to cope with problems or stresses presented by raising a child with developmental disabilities. These activities are provided by an appropriately licensed professional or through support groups.

"Family homes" means residences maintained by individuals persons biologically related to a person receiving services.

"Family training" means activities designed to equip family members, significant others, and persons with developmental disabilities with knowledge and skills ~~which that~~ allow a family member with developmental disabilities to remain in or return to his or her home.

"Goals" means long-term categorical statements ~~which that~~ describe what the individual service recipient is expected to achieve in a given time frame and are used synonymously with outcomes.

~~"Group home for developmentally disabled and physically disabled adults" means any establishment or institution other than a hotel, motel, fraternity or sorority house, or college or university dormitory for not more than 12 residents, 18 years of age or older who are developmentally disabled or physically disabled, and which offers or provides supervision, residential accommodations, food service, training and skill development opportunities designed to lead to increased independence of the residents, and supportive assistance to any of its residents requiring supportive assistance. Homes certified by OKDHS as foster homes, and living arrangements certified under the Adult Companion Home Certification Act, are not considered group homes.~~

"Guardian" means a ~~person(s)~~ person appointed by a court as general or limited guardian of the person, general or limited guardian of property, special guardian or temporary guardian as provided by state statutes to ensure the essential requirements for the health and safety of the ward are met, to manage the estate or financial resources of the ward, or both. ~~The term does not include a person(s) appointed as guardian ad litem.~~

"Guardian ad litem" means a ~~person(s)~~ person appointed by a court to represent the interests of ~~an individual~~ a person in a legal action.

~~"Guardianship Assessment Team" means the service recipient's core team members who are required to attend the Guardianship Assessment Team meeting.~~

~~(A) Members of the Guardianship Assessment Team include:~~

- ~~(i) the service recipient;~~
- ~~(ii) a personal advocate of the service recipient's choice;~~
- ~~(iii) service recipient's family member(s);~~
- ~~(iv) the service recipient's case manager;~~
- ~~(v) representative of the OKDHS Office of Client Advocacy, if the service recipient is residing in a resource center or is a member of the Homeward Bound class;~~
- ~~(vi) guardian ad litem representative, if identified as the service recipient's advocate;~~
- ~~(vii) a physician, if the service recipient resides at a resource center; and~~
- ~~(viii) a psychologist, if the service recipient resides at a resource center.~~

~~(B) Other team members whose presence is not required at the Guardianship Assessment Team meeting may be invited to participate as a Guardianship Assessment Team member, if these individuals know the service recipient well and have pertinent information for determining guardianship needs. Other Guardianship Assessment Team members may include:~~

- ~~(i) the service recipient's primary physician, if the service recipient receives community supports;~~
- ~~(ii) a psychologist, if the service recipient receives community services and the psychologist is a member of the service recipient's Personal Support Team; and~~
- ~~(iii) interested parties, such as friends, residential or vocational staff, or other contract professionals.~~

"Habilitation services" means goal-directed services and therapy activities;

~~(A) designed to assist a service recipient to achieve greater mental, physical, and social development; and~~

~~(B) Activities are based on the service recipient's capacity to make progressively independent and responsible decisions about:~~

- ~~(i) social behavior;~~
- ~~(ii) quality of life;~~
- ~~(iii) job satisfaction;~~ and

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(iv) ~~personal relationships. The goal of habilitation services is to strengthen developmental skills and resolve personal deficits that interfere with the service recipient's capacity to successfully remain in his or her home or other community-based settings.~~

~~"Homemaker services" means services which support persons receiving services in activities of daily living such as self care, non-specialized mobility, cooking, shopping, home maintenance, and transportation and which are performed by paraprofessional providers in the place of residence of the person receiving services.~~

~~"Human Rights Committee" means the committee charged with the responsibility for ensuring the legal external monitoring and ethical rights advocacy to address protection of individuals served individual rights.~~

~~"ICF/MR" means an intermediate care facility for the mentally retarded which that is:~~

~~(A) a residential facility licensed in accordance with state Oklahoma law; and~~

~~(B) certified by the federal government as a provider of Medicaid services to persons who have mental retardation (MR) or related conditions.~~

~~"Incapacitated" means a determination made by the court that a person is unable to provide for and make decisions for the person's own needs and safety. The term incapacitated is used to indicate full or partial incapacity.~~

~~"Individual Habilitation Plan (IHP Plan)" means a plan of intervention developed by the interdisciplinary team based upon assessment of need. It The Plan:~~

~~(A) specifies all the goals and objectives outcomes being pursued on behalf of the individual service recipient, the steps being taken to achieve them outcomes, and all of the services provided by each agency, and supports necessary to achieve outcomes; and~~

~~(B) The IHP is a single, consistent, and comprehensive plan that encompasses all relevant components of the individual's service recipient's life. Various aspects of the plan such as education, rehabilitation, health care, and others Plan are assigned to those persons or agencies who can best provide, or who are legally required designated by the Team to provide, the necessary services.~~

~~"Informed consent" means the voluntary consent by a person who has the legal capacity to consent after being informed of the nature, purpose, risks, and benefits of a proposed service or action.~~

~~"Intake" means the process by which an individual a person gains access to DDSD services. Intake staff:~~

~~(A) provide provides answers to specific service inquiries;~~

~~(B) assist assists in the identification of needs in times of crisis;~~

~~(C) supply supplies information regarding the range and means of accessing available services;~~

~~(D) provide provides assistance as necessary in service application; and~~

~~(E) facilitate facilitates eligibility determination; and~~

~~(F) provide follow up contacts as necessary to ensure that services fulfill need.~~

~~"Integrated vocational employment site" means a location or activity that provides regular interaction for service recipients with people persons without disabilities, excluding service providers, to the same extent that a non-disabled worker without disabilities in a comparable position interacts with others.~~

~~"Interdisciplinary Team (IDT)" means the decision making body for service planning, implementation, and monitoring of the Individual Plan. Refer to definition for Personal Support Team.~~

~~"Intrusive procedure" means a procedure that impinges upon the bodily integrity of the individual. Use of intrusive procedures is regulated by service recipient, per OAC 340:100-5-26, 340:100-5-57, and 340:100-5-58. Intrusive procedures include, but are not limited to:~~

~~(A) the use of injections or oral medications administered for the sole purpose of controlling behavior;~~

~~(B) physical management or physical restraint; and~~

~~(C) mechanical restraints for medical reasons.~~

~~"Job coach" means an individual a person who holds an OKDHS approved job coach certification and provides ongoing support services to eligible consumers service recipients in supported employment placements. Services directly support the service recipient's work activity, including:~~

~~(A) marketing and job development;~~

~~(B) job and work site assessment;~~

~~(C) the training and assessment for the workers;~~

~~(D) job matching procedures;~~

~~(E) development of developing co-worker supports both natural and paid; and~~

~~(F) teaching job skills.~~

~~"Least restrictive alternative" means an arrangement that allows the service recipient opportunities to exercise choice, interact with non-disabled citizens, and participate in rhythms of life free of programmatic oversight to the extent of services and supports that cause the least disruption or change in the service recipient's circumstances and maximizes the service recipient's unique abilities independence and freedom.~~

~~"Long-term resident" means any resident of a nursing facility with mental retardation MR or related conditions who has continuously resided in a nursing facility for at least 30 consecutive months prior to the date of the first preadmission screening and resident review (PASRR) disposition.~~

~~"Mental retardation (MR)" means a condition, per Diagnostic and Statistical Manual of Mental Disorders (DSM), that:~~

~~(A) refers to substantial limitations in present functioning;~~

~~(B) Mental retardation manifests before age 18; and~~

~~(C) It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the applicable adaptive skill areas of:~~

- (A~~i~~) communication;
- (B~~ii~~) self-care;
- (C~~iii~~) home living;
- (D~~iv~~) social skills;
- (E~~v~~) use of community resources;
- (F~~vi~~) self-direction;
- (G~~vii~~) health and safety;
- (H~~viii~~) functional academics;
- (I~~ix~~) leisure; and
- (J~~x~~) work.

"Natural supports" means assistance provided by a person, such as a service recipient's family, friend, co-worker, or neighbor, or member of a service recipient's club, church, or interest group, or others in the service recipient's community, who:

- (A) is not paid specifically to provide ~~support assistance~~ to the service recipient; and
- (B) ~~but who provides that support assistance voluntarily. Natural supporters might include family members, friends, co-workers, neighbors, church members, members of a service recipient's club or interest group, or others in the service recipient's community.~~

"Non-prescription medication" means a pharmacological drug that is sold without a prescription and is prepackaged for use by the service recipient and labeled in accordance with the requirements of state and federal statutes and regulations.

"Normalization" means a principle which advocates that services provided to persons with developmental disabilities are provided in accordance with commonly accepted patterns and conditions of life experienced by the general population.

"Nursing facility" means an Oklahoma Medicaid-certified institution providing skilled nursing and related services. ~~It does not include excluding a facility certified as an ICF/MR.~~

"Nutritional services" means ~~assessment, consultation, planning, and monitoring activities conducted by a registered dietitian.~~

"Occupational therapy services" means ~~assessment, consultation, planning, therapy, and monitoring activities conducted by an occupational therapist licensed by the Oklahoma Board of Medical Licensure and Supervision.~~

"OKDHS" means the Oklahoma Department of Human Services.

"Personal Support Team (Team)" means the decision-making body for service planning, implementation, and monitoring of the Individual service recipient's Plan. ~~The Team and~~ includes:

- (A) the service recipient; and
- (B) ~~his or her~~ service recipient's:
 - (i) case manager; and
 - (ii) the legal guardian; and
 - (iii) ~~the person's~~ advocate(s), if there is one when applicable, advocate, who may be a parent, a family member, a friend, or another who knows the person service recipient well; and
- (C) others, including service providers, whose participation is necessary to achieve the outcomes desired by the service recipient. ~~The term Personal Support Team replaces the term Interdisciplinary Team.~~

"Physical management" means an intrusive procedure involving any physical guidance of a service recipient to overcome resistance or brief upper body hold to ensure safety. ~~Use of physical management is regulated by per~~ OAC 340:100-5-57.

"Physical restraint" means an intrusive procedure in which the person service recipient is physically held to restrict movement.

"Physical Status Review" means Form ~~DDS-7 06HM007E~~, Physical Status Review, ~~which that~~ is a written assessment ~~that objectively identifies~~ identifying a service recipient's ~~functional~~ ability to attend to activities of daily living based on past and present health history and current treatment modalities. ~~The completed~~ Completed Form ~~DDS-7 06HM007E~~ assists the ~~consumer~~ service recipient and the ~~Team to identify in~~ identifying the:

- (A) service recipient's health care level; and
- (B) staff training requirements; and
- (C) health care coordination needs; and
- (D) ~~more~~ in-depth assessment needs.

"Physical therapy" means ~~assessment, consultation, planning, treatment, and monitoring activities conducted by a physical therapist licensed by the Oklahoma Board of Medical Licensure and Supervision.~~

"Plan of Care" means a summary listing of services prescribed within the ~~HHP, Plan which that~~ indicates the frequency amount, duration, and cost of each service recommended for funding through Home and Community Based Waivered Services (HCBWS) ~~DDSD HCBS Waivers~~. ~~This document is not required in service planning for individuals residing in an ICF/MR or who receive services funded through funding sources other than the Home and Community Based Services (HCBS) waiver.~~

"Preadmission screening and resident review (PASRR)" means the process of evaluating, reviewing, and establishing the need for nursing facility services in contrast to other services for people persons with mental retardation MR and related conditions.

"Prescription medication" means any drug ordered by a practitioner of medicine, dentistry, osteopathy, optometry, or podiatry who is licensed by law to prescribe ~~such drug(s), which is a~~ drug intended to be filled, compounded, or dispensed by a pharmacist.

"Prevocational services" means ~~services which are not job task oriented, but which are aimed at preparing a service recipient for paid or unpaid employment.~~

"p.r.n." means to take, or administer, a medication "as needed."

"Program coordinator" means a person employed by a DDSD residential or vocational contract provider agency who is responsible for the supervision, coordination, and monitoring of services provided by the contract agency to a service recipient ~~provided by the contract provider agency.~~

"Proper consent" means obtaining prior written approval of the individual or the legal guardian specific to the use of a particular treatment approach defined as intrusive or restrictive.

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"Psychological services" means assessment, consultation, planning, therapy, behavior treatment, and monitoring activities conducted by a licensed psychologist or by a psychological assistant.

"Psychotherapy services" means assessment, consultation, planning, therapy, and monitoring activities performed by a board-certified psychiatrist or licensed psychologist.

"Program manager" means a person employed by a DDSD employment contract provider agency who is responsible for the supervision, coordination, and monitoring of services provided by the contract agency to a service recipient.

"Psychotropic medication" means a pharmacological drug used to treat a mental disorder, or any drug prescribed to stabilize or improve mood, mental status, or behavior.

"QMRP" means a ~~Qualified Mental Retardation Professional~~. This is an individual qualified mental retardation professional who meets ICF/MR regulations as specified in Section 483.420 of Title 42 of the Code of Federal Regulations (CFR), Chapter IV, Section 483.420 (42 CFR § 483.420). This requires A QMRP must have a baccalaureate degree in a human services field, in addition to one year of experience serving persons with ~~mental retardation~~ MR.

"Related condition" means a severe, chronic disability, ~~per 42 CFR, Section § 435.1009,~~ that:

- (A) is attributable to:
 - (i) cerebral palsy; ~~or~~
 - (ii) epilepsy; or
 - ~~(iii)~~ (iii) any other condition, including autism. Any other condition excludes mental illness (MI) that is ~~found to be~~ closely related to ~~mental retardation (MR) because as~~ it results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required for persons with MR;
- (B) is manifested before the person reaches age 21;
- (C) is likely to continue indefinitely; and
- (D) results in substantial functional limitations in three or more areas of major life activity, ~~which include~~ including:
 - (i) self-care;
 - (ii) understanding and use of language;
 - (iii) learning;
 - (iv) mobility;
 - (v) self-direction; and
 - (vi) independent living.

"Respite care services" means in-home and out-of-home activities provided for the primary purpose of temporarily relieving the family or primary caregiver from the responsibility of care giving. Providers of this service may include individual providers, foster homes, group homes, and state-licensed and certified ICF/MR, or other multi-service agencies which achieve and maintain licensure in accord with state law and OKDHS rules and fulfill contract stipulations dictating required service, treatment, and environmental standards.

"Restrictive procedure" or "restriction" means a procedure that results in the limitation of the service recipient's

rights. ~~Use of restrictive procedures is regulated by per OAC 340:100-5-57 and 340:100-5-58. Restrictive procedures include and includes:~~

- (A) limiting communication with others;
- (B) any limitation of access to:
 - (i) leisure activities;
 - (ii) the service recipient's own money or personal property; and
 - (iii) goods or services beyond normal budgetary considerations;
- (C) any limitation of movement at home or in the community; or
- (D) any direct observation procedures, specified as a result of challenging behavior, such as continuous one-to-one staffing during times or places ~~which that~~ would otherwise be considered private.

"Sheltered employment" means a service ~~which that~~:

- (A) assists ~~workers service recipients~~ toward achieving their vocational potential through a controlled work environment;
- (B) ~~providing provides~~ worker reimbursement in accordance with individual production and the Fair Labor Standards Act (FLSA); and
- (C) ~~Sheltered employment services include~~ includes assessment, training, and transitional programming leading to community job placements.

"Sheltered workshop" means a facility ~~under the direction of a nonprofit organization~~ that provides vocational training and sheltered employment services for workers with disabilities. ~~Sheltered workshops often subcontract with businesses to provide work for the sheltered employees and typically pay their employees less than minimum wage, commensurate with the employee's production.~~

"Short-term resident" means any resident with ~~mental retardation~~ MR or related conditions who has resided in a nursing facility for less than 30 months prior to the date of the first PASRR disposition.

"Skilled nursing services" means ~~nursing services in the community including preventative and rehabilitative procedures that fall within professional and legal bounds and are ordered by an attending physician. These services are prescribed and nursing plans are written for individuals as a result of the individual planning process and are included in the Individual Plan.~~

"Specialized foster care" means residential service option for eligible individuals with developmental disabilities between the ages of six through 17 whose primary need is placement in a family setting.

"Specialized services" means individualized services specified by the Mental Retardation Authority and listed in PASRR evaluations which completed by DDSD that, combined with services provided by the nursing facility or other service providers, results in a treatment regimen leading to the continued and ongoing enhancement of independence.

"Speech therapy" means assessment, planning, therapy, consultation, and monitoring activities provided by a licensed speech and language pathologist.

"Supplemental Security Income (SSI)" means a federal income subsidy program administered by the Social Security Administration.

"Supported employment" means competitive work in an integrated work setting with ongoing support services for service recipient's recipients with severe disabilities for whom competitive employment has not traditionally occurred or has been interrupted or intermittent as a result of severe disabilities.

"Supported living arrangements" means a flexible array of habilitation and support services ranging from 24 hour in-home services to semi-independent living services which that provides an opportunity for an adult with developmental disabilities to live in his or her own home.

"Team leader" or "unit coordinator" means a professional employed by a public or private agency who is responsible for assuring that services to a service recipient are planned and provided in a coordinated fashion. Additional responsibilities include advocacy, service coordination, and monitoring activities with and on behalf of service recipients.

"Terminal illness" means, as certified by a physician, a condition that results in a person has a medical prognosis of life expectancy of six months or less and requires continuous nursing care or medical supervision and treatment to address the person's physical condition if the illness runs its natural course.

"Transition" means the planned movement of an individual a service recipient from one service setting to another, occurring as a result of Team recommendation and the informed consent of the service recipient.

"Transportation services" means services that include acquisition of, and training in support and payment for, the use of public or private transportation.

"Treatment team for specialized services" means the team whose purpose is to develop a prescribed plan of specialized services for each service recipient. The team:

- (A) is composed of the service recipient, guardian or advocate, nursing home representative, and other professionals and para-professionals as needed to develop a comprehensive plan of services; and
- (B) Additional team members might may include a psychologist, physical therapist, speech pathologist, physician, and nurse's aide among others. DDSD staff assist nursing facility based teams in plan development and implementation as needed.

"Vocational assessment" means the employment service evaluation, whether or not standardized procedures are employed, that:

- (A) identifies the unique preferences, strengths, and needs of the service recipient;
- (B) evaluates work skills and work behaviors;
- (C) is supplemented by personal interviews and behavioral observations; and
- (D) incorporates information that addresses the service recipient's:
 - (i) medical;
 - (ii) physical;
 - (iii) psychological;
 - (iv) social;

- (v) cultural; and
- (vi) educational goals and objectives; and
- (vii) as well as present and future employment options. The assessment is updated annually or more frequently as needed.

"Volunteer guardian" means a concerned citizen person unrelated to the service recipient who:

- (A) serves, unpaid, as guardian for a the service recipient; and is trained and certified by the volunteer guardianship agency; and
- (B) A volunteer guardian is appointed by the court and responsible to the court to ensure essential requirements for the care health and safety of the person service recipient are met.

"Volunteer guardianship coordinator" means a DDSD staff member who is responsible for the operation of the Volunteer Guardianship Program at the local level.

"Volunteer Guardianship Program" means a program which locates volunteers to serve as guardian for persons receiving services who are determined in need of a guardian and for whom no relative or friend is available to serve in that capacity.

"Volunteer Guardianship Program supervisor" means a DDSD State Office staff member who is responsible for the oversight of the program.

"Ward" means a person over for whom a guardian is appointed by the court.

SUBCHAPTER 3. ADMINISTRATION

PART 1. GENERAL ADMINISTRATION

340:100-3-1.1. Competency [REVOKED]

Persons, age 18 or older, who are receiving services are presumed competent unless adjudicated incapacitated by a court of competent jurisdiction.

- (1) No recipient of services is considered incapacitated solely by reason of his or her receipt of services or admission to a facility.
- (2) The Guardianship Assessment Team completes a guardianship assessment, in accordance with OAC 340:100-3-5, for an individual who has not been legally determined incapacitated when it is determined that the individual needs assistance in managing his or her affairs.
 - (A) The Guardianship Assessment Team considers interventions that are less restrictive than guardianship including:
 - (i) durable power of attorney;
 - (ii) representative payee;
 - (iii) an independent advocate; or
 - (iv) medical proxy.

(B) When appropriate according to the guardianship assessment, the Team pursues appointment of an advocate or guardian in accordance with OAC 340:100-3-5, 340:100-3-5.1, 340:100-3-5.2, and

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~~Section 1-101 et seq of Title 30 of the Oklahoma Statutes.~~

~~(3) A person may be adjudicated incapacitated in one area while being fully capable of understanding and exercising his or her rights in other areas in a responsible manner. Each person is assured the right to exercise judgment in all areas of competence.~~

340:100-3-5. Advocacy and guardianship

~~(a) **Purpose.** Developmental Disabilities Services Division (DDSD) ensures that appropriate actions are taken. Advocacy and Guardianship Program identifies the advocacy needs of each service recipient to protect the service recipient's interests, rights, and welfare of clients in accordance with their need for advocacy and guardianship services.~~

~~(1) If a client is determined by the interdisciplinary team to be incapable of understanding any or all of his/her rights and responsibilities and of giving informed consent, the interdisciplinary team will make a recommendation for client representation by an advocate or a guardian. The interdisciplinary team will designate a party(ies) responsible for implementing the recommendation.~~

~~(2) Each client's current advocacy/guardianship status is reviewed at least annually and documented in the Individual Habilitation Plan.~~

~~(31) Only Although a service recipient may have other advocates, only a legally appointed guardian can may act on behalf of an individual who has been declared incapacitated by an authorized court of law and only his or her ward, per OAC 340:100-1-2, to the extent authorized in the guardianship order and Title 30 of the Oklahoma Statutes (O.S.).~~

~~(42) Guardians are Each guardian is:~~

~~(A) responsible for representing the interest of clients his or her ward as provided by state Oklahoma law; and~~

~~(B) obligated to involve the ward in decision-making to the extent that the ward is able.~~

~~(53) Advocates are An advocate is responsible for assisting clients the service recipient to represent their own (the client's) interests of the service recipient.~~

~~(b) **Capacity to give informed consent.** Service recipients, age 18 or older, are presumed to have capacity to give informed consent except to the extent adjudicated incapacitated by the court. A service recipient:~~

~~(1) is not considered incapacitated solely by reason of his or her diagnosis or admission to:~~

~~(A) Northern Oklahoma Resource Center of Enid (NORCE);~~

~~(B) Southern Oklahoma Resource Center (SORC); or~~

~~(C) Robert M. Greer Center (Greer);~~

~~(2) may be adjudicated incapacitated in one area while being fully capable of understanding and exercising his or her rights in other areas; and~~

~~(3) has the right to exercise judgment in all areas of capacity.~~

~~(c) **Assessment of capacity to give informed consent.** Each service recipient's current need for advocacy or guardianship services is reviewed at least annually and documented in the Needs Assessment or Individual Plan (Plan).~~

~~(1) Form 06MP032E, Capacity Assessment, is:~~

~~(A) used to determine the service recipient's capacity to give informed consent and identify the type of assistance, if any, the service recipient needs to make life decisions and be protected from abuse, neglect, and exploitation; and~~

~~(B) completed for each:~~

~~(i) adult and minor attaining the age of 17 $\frac{1}{2}$ years, who receives residential services through the Community Waiver or Homeward Bound Waiver;~~

~~(ii) child in OKDHS custody who receives DDSD services upon reaching the age of 16 per OAC 340:75-8-39; and~~

~~(iii) resident older than age 17 $\frac{1}{2}$ residing in:~~

~~(I) NORCE;~~

~~(II) SORC; or~~

~~(III) Greer.~~

~~(2) In order for the Assessment Team to meet to complete Form 06MP032E, all members are notified of the meeting at least two weeks in advance and offered the opportunity to provide written input if they cannot attend. The Assessment Team includes:~~

~~(A) all members of the Personal Support Team;~~

~~(B) the service recipient's primary physician, if the service recipient resides at NORCE, SORC, or Greer; and~~

~~(C) a licensed psychologist or psychiatrist, if the service recipient resides at NORCE, SORC, or Greer.~~

~~(3) For service recipients who do not receive residential services per OAC 340:100-5-22:~~

~~(A) a capacity assessment is not required. If the family or service recipient wishes to complete a capacity assessment, the DDSD case manager includes this assessment as an outcome in the Needs Assessment or Plan, and the family participates in the assessment process; and~~

~~(B) a review of the service recipient's legal status must occur annually and be addressed in the Needs Assessment, using Forms 06MP033E, Guardianship, Advocacy, and Capacity Initial Review, and 06MP034E, Guardianship, Advocacy, and Capacity Annual Review. If this review indicates needs in the area of advocacy, the DDSD case manager offers a capacity assessment.~~

~~(d) **Recommendations of Assessment Team.** DDSD supports the use of less restrictive alternatives to guardianship.~~

~~(1) The Assessment Team recommends guardianship after they have considered and ruled out less restrictive alternatives to guardianship. Alternatives include, but are not limited to:~~

~~(A) guidance and support from family or friends;~~

~~(B) volunteer advocate;~~

- (C) modification of the Plan to more effectively meet the service recipient's health, safety, and financial needs;
 - (D) representative payee;
 - (E) limited bank accounts;
 - (F) power of attorney, durable power of attorney, or durable power of attorney with health care powers;
 - (G) Advance Directive for Health Care;
 - (H) trust fund; or
 - (I) conservatorship.
- (2) If Form 06MP032E indicates that a guardian is needed, the Personal Support Team recommends an appropriate person to serve.
- (A) Priority for persons to serve as guardians is given to:
 - (i) any person nominated by the service recipient pursuant to Section 3-102 of Title 30 of O.S. (30 O.S. § 3-102);
 - (ii) a current guardian appointed by an appropriate court in another jurisdiction;
 - (iii) a person nominated by will or other writing of a deceased parent, spouse, or adult child who was serving as the service recipient's guardian pursuant to 30 O.S. § 3-103;
 - (iv) the spouse of the service recipient;
 - (v) an adult child of the service recipient;
 - (vi) a parent(s) of the service recipient;
 - (vii) a sibling of the service recipient;
 - (viii) a person with whom the service recipient has been living for more than six months prior to the filing of the petition for guardianship. OKDHS providers must not be appointed guardian of such service recipient unless the provider is a relative within the second degree of consanguinity, such as mother, father, sibling, child, aunt, uncle, niece, nephew, grandparent, and grandchild;
 - (ix) other relatives of the service recipient, such as grandparent, grandchild, aunt, uncle, niece, or nephew; or
 - (x) other relatives of the service recipient who are not residents of Oklahoma, per 30 O.S. § 4-104.
 - (B) If an appropriate relative is not available, a volunteer is sought in accordance with OAC 340:100-3-5.1.
- (e) **Guardianship eligibility requirements.**
- (1) A guardian must:
 - (A) be at least 18 years of age;
 - (B) be a resident of Oklahoma for at least one year, except as provided in 30 O.S. § 4-104; and
 - (C) not be under any financial obligation to the proposed ward.
 - (2) An incapacitated or partially incapacitated person cannot be appointed guardian.
 - (3) A convicted felon cannot be appointed guardian, except upon:
 - (A) further review by the court into the nature of the felony; and
 - (B) court approval.
- (f) **Responsibilities of a guardian.**
- (1) The guardian:
 - (A) is responsible for protecting the rights of the ward per 30 O.S. § 1-103;
 - (B) files Plan for the Care and Treatment of the Ward, with the court within ten days of appointment as guardian;
 - (C) files Administrative Office of the Courts (AOC) Form 34, Report on the Guardianship of the Person, AOC Form 34a, Report on the Guardianship of Property, or both, with the court. Assistance in completing these annual reports may be obtained from the DDS case manager or guardianship coordinator. The guardian may also hire an attorney to prepare annual reports for a fee;
 - (D) has a legal duty to:
 - (i) know the service recipient, including his or her capabilities, needs, and physical and mental health;
 - (ii) maintain contact with the service recipient;
 - (iii) ensure the service recipient is living in the least restrictive environment that meets his or her needs;
 - (iv) provide necessary consents authorized by the court; and
 - (v) notify the court if the service recipient's incapacity has ended; and
 - (E) has limited authority pursuant to 30 O.S. § 3-119 and the guardianship order that sets forth the limitation of powers of a guardian by prohibiting the guardian from consenting on behalf of the ward to the withholding or withdrawal of life-sustaining procedures except with specific authorization of the court having jurisdiction over the guardianship proceedings. Authorization must be granted in a separate court order and only at such time when the ward is in need of life-sustaining treatment.
 - (2) When performing duties and exercising authority, the guardian:
 - (A) ensures the interests, rights, and welfare of the ward are protected;
 - (B) may act independently, if necessary, from provider agency staff and DDS staff;
 - (C) encourages the ward to:
 - (i) participate to the maximum extent possible in all decisions that affect the ward; and
 - (ii) act on all matters in which the ward is able to do so within the limitations imposed by the court; and
 - (D) as appropriate, assists the ward to develop or regain, to the maximum extent possible, his or her capacity to meet the essential requirements for health or safety.
- (g) **Changes in guardianship.** The ward, any person interested in the welfare of the ward, or a guardian may make application to the court for:
- (1) termination of the guardianship;
 - (2) removal of a guardian;

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- (3) imposition of additional restrictions or the removal of existing restrictions; or
- (4) a review hearing.
- (h) **Costs and fees.** Court costs are not charged for filing guardianship petitions and reports for persons who are applicants for or recipients of Social Security, per 56 O.S. § 192.
- (i) **Responsibilities of OKDHS Legal Division.** If a guardian cannot be found for a resident of NORCE, SORC, or Greer, OKDHS Legal Division has the authority, per 10 O.S. § 1415, to file a petition for the appointment of a guardian ad litem for the service recipient.
 - (1) Legal Division attorneys do not provide any legal services to any other party or potential party in guardianship cases.
 - (2) The only legal services provided are to ensure compliance with 10 O.S. § 1415. No other legal services in connection with these guardianships are provided directly or indirectly by OKDHS.

340:100-3-5.1. Volunteer Guardianship Program guardianship

(a) **Purpose.** Developmental Disabilities Services Division assures that guardians are provided (DDSD) contracts with an agency to maintain a system to recruit, screen, match, monitor, and support volunteer guardians for eligible service recipients, of Developmental Disabilities Services Division (DDSD). To be eligible, the service recipient must:

- (1) be assigned a DDSD case manager;
 - (2) who have been determined through an the capacity assessment process, per OAC 340:100-3-5, to need guardianship a guardian; and for whom a guardian is unavailable through relatives or friends. A system to locate, screen, match, and monitor volunteer guardians for these service recipients is established and maintained by DDSD.
 - (3) have no relative appropriate to serve as guardian.
- (b) **Responsibilities of Developmental Disabilities Services Division DDSD.** DDSD responsibilities in the Volunteer Guardianship Program are given in this subsection.

- (1) When the need for a volunteer guardian has been determined through the capacity assessment process, per OAC 340:100-3-5, and a potential guardian is not identified by the Assessment Team, the DDSD case manager is responsible for locating a potential guardian for the service recipient. In the absence of a forwards Form 06MP032E, Capacity Assessment, with a recommendation for a volunteer guardian to the DDSD case manager, the volunteer guardianship coordinator assumes responsibility for identifying a potential guardian management supervisor. In attempting Documentation of attempts made to locate a potential volunteer guardian, the case manager follows outlined procedures before reporting results to the Personal Support Team (Team) among those who are eligible per OAC 340:100-3-5, must be included. The Team makes a recommendation for an individual to be appointed guardian.
- (2) Before recruiting a volunteer guardian, individuals are contacted and considered in the order listed in (A) (J)

of this paragraph as provided in Section 3-104 of Title 30 of the Oklahoma Statutes (O.S.). Persons considered are:

- (A) an individual(s) nominated by the service recipient according to Section 3-102 of Title 30 of O.S.;
- (B) a current guardian appointed by the court;
- (C) an individual nominated by will or other writing of a deceased parent, spouse or adult child who was serving as the guardian of the service recipient according to Section 3-103 of Title 30 of O.S.;
- (D) the spouse of the service recipient;
- (E) an adult child of the service recipient;
- (F) a parent of the service recipient;
- (G) a sibling of the service recipient;
- (H) an individual with whom the service recipient has been living for more than six months prior to the filing of the petition per (c)(1)(D) of this Section;
- (I) other relatives of the service recipient such as grandparent, grandchild, aunt, uncle, niece, or nephew; or
- (J) other relatives of the service recipient who are residents of Oklahoma, according to Section 4-104 of Title 30 of O.S.

(3) If a potential guardian is not found, the case manager submits a request to the volunteer guardianship coordinator for volunteer guardianship services. The request includes documentation of attempts to locate a guardian.

(2) The DDSD case management supervisor reviews the documents and, if approved, forwards the documents to the guardianship coordinator.

(3) The guardianship coordinator reviews Form 06MP032E and, if approved, makes a referral to the volunteer guardianship agency to initiate the process to recruit a volunteer guardian.

(c) **Volunteer guardianship eligibility requirements.** Volunteer guardianship In addition to requirements per OAC 340:100-3-5, eligibility requirements are criteria for volunteer guardians listed in (1) - through (46) of this subsection apply.

(1) In order to be considered for a volunteer guardianship position, the criteria listed in (A) through (E) of this paragraph must be met.

- (A) Volunteer guardians must be at least 18 years of age.
- (B) An incapacitated or partially incapacitated person cannot be appointed guardian.
- (C) Volunteer guardians must be residents of Oklahoma for at least one year, except as provided in Section 4-104 of Title 30 of O.S.
- (D) As(1) A corporate officer, member of the board of directors, owner, operator, administrator, or employee of a facility subject to provisions of the Nursing Home Care Act, the Residential Home Care Act Section 1-1901 et seq. of Title 63 of the Oklahoma Statutes (63 O.S. § 1-1901 et seq.) or the Group Homes for Persons with Developmental or Physical Disabilities Act 10 O.S. § 1430.1 et seq. or any other Oklahoma Department of Human Services (OKDHS) DDSD provider cannot is ineligible to be appointed volunteer guardian of a person receiving

services from that provider agency or provider except as outlined in Section 3-104 of Title 30 of O.S.

(A) An immediate family member of an ineligible person cannot serve as a volunteer guardian.

(B) An extended family member of an ineligible person cannot serve as a volunteer guardian when there is evidence that financial interdependence exists.

(2) Employees of DDS cannot serve as volunteer guardians.

(A) An immediate family member of the DDS employee cannot serve as a volunteer guardian, if the employee is a member of the service recipient's Personal Support Team.

(B) An extended family member of the DDS employee cannot serve as a volunteer guardian when there is evidence that financial interdependence exists, and the employee is a member of the service recipient's Personal Support Team.

(3) Any exceptions to the selection of a volunteer guardian, per OAC 340:100-3-5.1(c)(1) and (2) must be approved by the DDS director or designee.

(4) Employees of Oklahoma Department of Human Services (OKDHS) cannot serve as volunteer guardians for residents of Northern Oklahoma Resource Center of Enid (NORCE), Southern Oklahoma Resource Center (SORC), or Robert M. Greer Center (Greer), per 10 O.S. § 1415.

(E) A(5) Potential guardians must:

(A) pass a background check is completed on potential volunteer guardians, including, but not limited to a check of the OKDHS Community Services Worker Registry;

(2B) Volunteers must possess the willingness and ability to devote time and energy to serve as guardian; including physical and emotional ability.

(3) Volunteer guardians must be court appointed.

(4) In accordance with Section 4-101 of Title 30 of O.S., a person cannot be appointed guardian for more than five people.

(C) be certified by the volunteer guardianship agency; and

(D) approved by the Personal Support Team.

(6) A volunteer guardian:

(A) supports the philosophy and values consistent with the DDS mission statement per OAC 340:100-1-3.1; and

(B) serves no more than two wards unless approved in advance in writing by the DDS director or designee.

(d) **Responsibilities of a volunteer guardian.** The responsibilities of a volunteer guardian are provided outlined in this subsection OAC 340:100-3-5.

(1) The volunteer guardian is responsible for protecting the rights of the service recipient according to Section 3-118 of Title 30 of O.S.

(A) The guardian files a plan of care with the court within ten days of appointment as guardian.

(B) The guardian files an annual report d with the court. Assistance in completing the annual report may be obtained from the case manager or volunteer guardianship program staff.

(C) The volunteer guardian is under legal duty to:

(i) know the service recipient, including his or her capabilities, needs, and physical and mental health;

(ii) maintain contact with the service recipient;

(iii) ensure the service recipient is living in the least restrictive environment which meets his or her needs;

(iv) provide necessary consents authorized by the court; and

(v) notify the court if the service recipient's incapacity has ended.

(D) A volunteer guardian's power is limited according to Section 3-119 of Title 30 of O.S.

(2) In performing their duties and exercising their powers, volunteer guardians:

(A) ensure the rights of the ward are protected;

(B) encourage the ward to participate to the maximum extent of his or her abilities in all decisions which affect the ward and to act on his or her own behalf on all matters in which the ward is able to do so within the limitations imposed by the court; and

(C) as appropriate, assist the ward to develop or regain to the maximum extent possible his or her capacity to meet the essential requirements for his or her health or safety.

(e) **Changes in guardianship.** The ward, any person interested in the welfare of the ward, or a volunteer guardian may make application to the court for:

(1) termination of the guardianship;

(2) removal of a guardian;

(3) imposition of additional restrictions or the removal of existing restrictions; or

(4) a review hearing.

(f) **Costs and fees.** Court costs are not charged for filing petitions and reports for individuals who are applicants for or recipients of Social Security, according to Section 192 of Title 56 of O.S.

(g) **Preparation of guardianship papers.** Preparation of the guardianship petition can be completed through different processes.

(1) The services of an attorney may be acquired. Some attorneys prepare the necessary legal papers for indigent individuals pro bono.

(2) Necessary paperwork for DDS service recipients is prepared by the OKDHS Legal Division.

(3) Petition for guardianship can be completed by the potential volunteer guardian. If the subject of the proceeding is not represented by an attorney, the court may appoint an attorney.

(e) **Guardianship voucher.** After certification by the volunteer guardianship agency and approval by the Personal Support Team and, if able, the service recipient, the volunteer applies for and receives Form 06MP031E, Guardianship

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Voucher, per OAC 340:100-3-5.2, to pay the attorney fee necessary to file the guardianship petition.

~~(hf) **Monitoring of volunteer guardians.** Monitoring of the volunteer guardian is provided by the volunteer guardianship coordinator agency according to requirements specified in the OKDHS contract with the agency. The volunteer guardianship coordinator meets with the volunteer guardian at least annually or as needed.~~

~~(ig) **Training requirements for volunteer guardians.** (4) Volunteer guardians must participate in guardianship training on the regarding guardianship responsibilities, duties, and limitations on the powers of serving as a guardian.~~

~~(1) Training is arranged provided by DDS the volunteer guardianship agency with no cost to the volunteer guardian.~~

~~(2) Volunteer guardians receive orientation to applicable OKDHS rules and procedures regarding volunteer programs. Volunteer guardians are informed they are not covered by the 51 O.S. § 151 et seq., The Governmental Tort Claims Act, because as they are not authorized to act in on behalf of OKDHS, nor can they be so authorized without creating a conflict of interest in their roles as guardians.~~

~~(jh) **Responsibilities of volunteer guardianship coordinator agency.** The volunteer guardianship coordinator is responsible for the operation of the program on the local level. Duties of the volunteer guardianship coordinator agency include:~~

~~(1) reviewing guardian request and documentation;~~

~~(2) recruiting concerned citizens volunteers to act serve as volunteer guardians;~~

~~(3) requesting obtaining background checks of potential volunteer guardians;~~

~~(4) contacting references. The volunteer guardianship coordinator sends OKDHS Form Vol-7, Volunteer Reference Letter, to agency contacts a minimum of three references. If responses are not received, follow up contact is made negative or if three references cannot be found, the volunteer is not considered;~~

~~(5) bringing the recommendation before submitting volunteer guardianship recommendations to the Personal Support Team for review when a potential volunteer is identified and approval;~~

~~(6) arranging visits with the potential between potential volunteer guardians and service recipient recipients;~~

~~(7) arranging providing guardianship training and providing orientation on OKDHS rules and procedures, including 51 O.S. § 151 et seq.; and~~

~~(8) monitoring in accordance with subsection (h) of this Section. OAC 340:100-3-5.1(f); and~~

~~(9) providing technical assistance as requested by the volunteer guardian or DDS case manager, including:~~

- ~~(A) attending any team meetings;~~
- ~~(B) accompanying the volunteer on home visits;~~
- ~~(C) reviewing legal or specific documents or records regarding the service recipient; and~~

~~(D) providing reminders of due dates for annual court reports and, if needed, providing assistance to complete the reports.~~

~~(k) **Responsibilities of Volunteer Guardianship Program manager.** The Volunteer Guardianship Program manager is responsible for oversight of the program which includes:~~

~~(1) completing and reviewing background checks for volunteer guardians;~~

~~(2) supervising and assisting in volunteer recruitment;~~

~~(3) reviewing assessment of competency for leads on potential guardian;~~

~~(4) writing and interpreting the DDS Volunteer Guardianship Program rules and procedures;~~

~~(5) developing and conducting training for volunteer guardians;~~

~~(6) performing on sight reviews of local Volunteer Guardianship Program; and~~

~~(7) approving any volunteer as a potential guardian.~~

~~(l) **Responsibilities of Legal Division.** OKDHS Legal Division has legal authority according to Section 1415 of Title 10 of O.S. to file a petition for the appointment of a guardian for residents of OKDHS operated facilities for the mentally retarded. The Legal Division attorneys cannot provide any legal services to any other party or potential party in the guardianship cases, including the volunteer guardian or DDS service recipient. The only legal services that are provided are to ensure compliance with Section 1415 of Title 10 of O.S. Other legal services in connection with these guardianships are not provided directly or indirectly by OKDHS.~~

340:100-3-5.2. Guardianship voucher program Voucher Program

~~(a) **Scope and applicability.** Pursuant to Section 1415E of Title 10 and Section 228 of Title 56 of the Oklahoma Statutes, provide the legal basis for the Oklahoma Department of Human Services (OKDHS) to may pay for legal fees to initiate associated with guardianship proceedings for persons who:~~

~~(1) receive Developmental Disabilities Services Division (DDS) Home and Community-Based Waiver Services; (HCBS) Waiver; or~~

~~(2) who are residents of the Northern Oklahoma Resource Center of Enid (NORCE), the Southern Oklahoma Resource Center of Pauls Valley (SORC), and the Robert M. Greer Center (Greer).~~

~~(b) **Payment.** Payment for legal services is contingent upon availability of resources and does not exceed \$700 per service recipient.~~

~~(c) **Participation.** Participation in the guardianship voucher program Guardianship Voucher Program extends only to those service recipients who have been determined, by a Developmental Disabilities Services Division (DDS) Guardianship Assessment Team per OAC 340:100-3-5, to need a service listed in subsection (d) of this Section OAC 340:100-3-5.2.~~

~~(d) **Services.** Payment may be made for legal services necessary to:~~

- ~~(1) establish guardianship;~~
- ~~(2) replace, change, or add a guardian;~~
- ~~(3) appoint a successor guardian;~~

- (4) alter the terms or level of an established guardianship;
 - (5) establish less restrictive alternatives such as conservatorship; or
 - (6) restore the ward's capacity.
- (e) **Subsequent services.** Requests for payment for subsequent legal services related to the guardianship of the same service recipient may be approved by the DDSO director or designee.
- (f) **Eligibility.** ~~The eligibility requirements of the guardian or potential guardian for participation in the guardianship voucher program are explained in this subsection.~~ (1) ~~The guardian(s) or potential guardian(s) applying for a voucher must be:~~
- (1) a relative of the service recipient or a volunteer guardian certified in accordance with OAC 340:100-3-5.1; and
 - (2) ~~The guardian(s) or potential guardian(s) must be recommended by the DDSO Guardianship Assessment Personal Support Team.~~
- (g) **Financial eligibility.** ~~Financial eligibility for participation in the guardianship voucher program is explained in this subsection.~~
- (1) ~~Certified Approved~~ prospective volunteer guardians are exempt from financial eligibility requirements.
 - (2) ~~Immediate family members are~~ When the spouse, mother, or father of the service recipient is applying to be the guardian, such applicant is subject to financial eligibility requirements. To be financially eligible to receive a guardianship voucher, the annual adjusted gross income of the applicant spouse or household income of the applicant mother or father of the service recipient must be \$60,000 or less.
 - (A) ~~For the purposes of this Section, the term "immediate family member" includes spouse, mother, or father.~~
 - (3) Other relatives who desire to become the service recipient's guardian are ~~not required to meet~~ exempt from the financial eligibility criteria.
 - (B) ~~To be financially eligible to participate in the guardianship voucher program, the annual adjusted gross income (AGI) of the immediate family member applicant or co-applicants must be \$60,000 or less. Immediate family member applicants whose AGI exceeds \$60,000 are not eligible for the guardianship voucher program.~~
- (h) **Application Guardianship voucher application.** ~~The application process for the guardianship voucher program is explained in this subsection.~~
- (1) ~~Applications are~~ Form 06MP030E, Guardianship Voucher Application, is available from the DDSO case manager assigned to the service recipient, the area guardianship coordinator, resource center guardianship coordinator, or volunteer guardianship agency.
 - (2) ~~The guardian(s) or potential guardian(s) spouse, mother, or father~~ making application for the guardianship voucher program must ~~return the~~ submit required income

~~verification, according to subsection (j) of this Section per OAC 340:100-3-5.2(i).~~

(3) Applications are sent to the DDSO guardianship programs manager.

(34) Any incomplete application is returned to the applicant ~~identifying the missing information for correction.~~

(4) ~~The completed application is date stamped upon receipt in the DDSO State Office. The date the application is received establishes the chronological placement of the completed application after the effective date of the statutes establishing the guardianship voucher program.~~

(5) Applications for the guardianship voucher program are considered in chronological order of receipt in the DDSO State Office.

(6) The number of applications approved is determined by available funding. Applications not approved during a fiscal year due to insufficient funding are placed on a waiting list in the chronological order received and are processed as funds become available.

(i) **Verification of income.** ~~The If the applicant must provide is the spouse, mother or father of the service recipient,~~ verification of annual income must be provided. Acceptable forms of verification include a signed copy of the applicant's most recent federal income tax return or documentation of all sources of income from Supplemental Security Income, Temporary Assistance for Needy Families, child support, alimony, other state or federal subsidy, or other types of income.

(j) **Notification of application status.** The applicant is provided written notice of approval, ~~or denial, or placement on the~~ waiting list of the application for the guardianship voucher program within 30 calendar days of receipt of a completed application ~~Form 06MP030E in the DDSO State Office.~~

(k) **Issuance and expiration of guardianship voucher.** When an application for the guardianship voucher program is approved, a dated ~~voucher~~ Form 06MP031E, Guardianship Voucher, is issued to the applicant who then seeks and retains legal counsel of ~~his or her choice.~~ Each voucher Form 06MP031E is approved for use from the date of issuance and is valid for 365 days from the date of issuance. ~~On the 366th day from the date of issuance, the voucher expires, and voucher funding is no longer encumbered for the expired voucher.~~

(l) **Submitting voucher for payment.** Upon completion of the guardianship proceedings, the attorney who provides the service submits ~~the voucher~~ Form 06MP031E to DDSO State Office for payment. A copy of all pleadings filed, the letters of guardianship, the guardianship order, Plan for the Care and Treatment of the Ward, and an itemized bill for legal services must be attached to ~~the voucher~~ Form 06MP031E. ~~The voucher Form 06MP031E and required documentation must be received by the supervisor of the DDSO guardianship voucher program programs manager~~ within 365 days from the date of issuance, or ~~the voucher~~ Form 06MP031E expires and becomes is null and void.

(m) **Fair hearing.** ~~An individual~~ Any person who has been denied a voucher may request a hearing in accordance with OKDHS fair hearing policy OAC 340:2-5.

(n) **Annual report.** ~~Any guardian receiving financial assistance under this Section is responsible for sending a copy of~~

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the Annual Report to the court and to the DDS State Office within 30 days of submission to the court.

PART 3. OPERATIONS

340:100-3-33.2. Provision of waiver services by legally responsible persons and other family members or guardians

(a) Legally responsible persons.

(1) Persons who are legally responsible for the care of service recipients are prohibited from providing Developmental Disabilities Services Division (DDSD) Home and Community-Based Waiver Services to service recipients for whom they are responsible.

(2) For purposes of OAC 340:100-3-33.2, a person who is legally responsible is:

- (A) a biological or adoptive parent(s) of a minor child;
- (B) a legal guardian of a minor child;
- (C) a spouse of a service recipient; or
- (D) anyone deemed legally responsible by court order.

(b) Family members or guardians not legally responsible. Family members or guardians who are not legally responsible for the care of service recipients:

(1) may provide Home and Community-Based Services (HCBS) under specific circumstances when they:

- (A) are qualified per applicable Oklahoma Department of Human Services (OKDHS) and Oklahoma Health Care Authority (OHCA) rules; and
- (B) meet specific service provider requirements;

(2) must be employed by provider agencies, except per OAC 340:100-3-33.2(b)(3). Provider agencies must:

- (A) provide supervision and oversight of such employees; and
- (B) ensure claims are submitted only for services rendered;

(3) are prohibited from being paid as direct contract providers of DDSD HCBS, except when such persons are:

- (A) the only available provider of covered services due to geographic remoteness; or
- (B) uniquely qualified to provide covered services due to considerations such as language; and

(4) may provide services, such as:

- (A) audiology;
- (B) dental;
- (C) respite;
- (D) agency companion;
- (E) assistive technology;
- (F) homemaker;
- (G) habilitation training specialist;
- (H) nutrition;
- (I) occupational therapy;
- (J) physical therapy;
- (K) speech therapy;
- (L) transportation; and
- (M) specialized foster care.

(c) Volunteer guardians. Volunteer guardians appointed by the court, per OAC 340:100-3-5.1, are prohibited from providing DDSD HCBS to their wards.

340:100-3-34. Incident reporting

(a) Reporting requirement. ~~The rules in this Section direct contract providers~~ Contract provider staff and Developmental Disabilities Services Division (DDSD) staff to must report injuries and behavioral or health-related incidents involving any person receiving DDSD services or waiver funded services, other than excluding Family Support Assistance as explained in Payment Program per OAC 340:100-13.

(b) Critical incidents. ~~The DDSD case manager or, if the incident occurs outside regular working hours, the DDSD emergency on call system is notified immediately when~~ Critical incidents include:

- (1) a person receiving services dies;
- (2) a person receiving services has an injury or health-related event which requires:
 - (A) consult with a physician;
 - (B) treatment by a physician or in a hospital emergency room;
 - (C) transport by ambulance; or
 - (D) hospitalization;
- (3) law enforcement is contacted or involved in a situation;
- (4) suspected abuse, neglect, financial exploitation, or sexual exploitation is suspected of a service recipient;
- (5) there is harm to a person as a result of physical aggression;
- (6) physical restraint is used;
- (7) there is deliberate harm to an animal; or
- (8) an incident results in suspension, removal, or termination of the person's program.
- (2) threatened or attempted suicide by a service recipient;
- (3) death of a service recipient;
- (4) an unplanned hospital admission of a service recipient;
- (5) a medication event resulting in emergency medical treatment for a service recipient;
- (6) law enforcement involvement in a situation concerning a service recipient;
- (7) property loss of more than \$500 involving a service recipient;
- (8) a service recipient who is missing;
- (9) an unusual or significant incident involving a service recipient that may attract media attention; and
- (10) a highly restrictive procedure used on a service recipient, such as:
 - (A) p.r.n. medication for behavioral control; and
 - (B) physical hold.

(c) Non-critical incidents. ~~A Form DDS 46, Incident Report, is completed when~~ Non-critical incidents include:

- (1) any incident listed in subsection (b) of this Section takes place;

- ~~(21) an injury occurs that does not require an intervention listed in paragraph (b)(2) of this Section to a service recipient;~~
- ~~(3) an incident is suspicious, unusual, or unexplained;~~
- ~~(2) an unplanned health-related event involving a service recipient;~~
- ~~(3) physical aggression by a service recipient;~~
- ~~(4) fire setting by a service recipient;~~
- ~~(5) deliberate harm to an animal by a service recipient;~~
- ~~(46) there is destruction of property loss of less than \$500 involving a service recipient; or~~
- ~~(7) a vehicle accident involving a service recipient;~~
- ~~(8) the suspension, termination, or removal of a service recipient's program, including employment; and~~
- ~~(52) there is a medication event involving a service recipient, which includes including:~~
 - ~~(A) dosage dose at the wrong time;~~
 - ~~(B) missed dose;~~
 - ~~(C) wrong dose;~~
 - ~~(D) wrong medicine;~~
 - ~~(E) wrong route;~~
 - ~~(F) incorrect medicine label or instructions;~~
 - ~~(G) the person refused the medication by the service recipient;~~
 - ~~(H) the incorrect medication is documented incorrectly documentation; or~~
 - ~~(I) another any other significant occurrence involving medication.~~

~~(d) The contract provider or DDS staff member who witnessed or has knowledge of the incident immediately completes Form DDS 46, Incident Report, supported if necessary by written statements from witnesses, and notifies program coordination staff in accordance with DHS or provider agency policy, whichever is applicable.~~

~~(ed) **Incident notification requirements.** The When an incident occurs, contract provider staff notifies:~~

- ~~(1) the person's family or legal guardian, in accordance with provider policies;~~
- ~~(21) the DDS case manager in accordance with subsection (b) of this Section; immediately when there is a critical incident per OAC 340:100-3-34(b). If the incident occurs outside regular working hours, DDS on-call staff is notified immediately.~~
 - ~~(A) If the When contract provider staff notifies the emergency on-call system staff, the DDS case manager must be notified within one working day of the incident.~~
 - ~~(B) Contract provider staff provide a legible copy of the submits Form DDS 46-06MP046E, Incident Report, to the DDS case manager and DDS State Office within 72 hours after the incident;~~
- ~~(2) the DDS case manager by Form 06MP046E within 72 hours of the occurrence of a non-critical incident per OAC 340:100-3-34(c);~~
- ~~(3) the service recipient's family or guardian, in accordance with provider policies;~~
- ~~(34) other individuals persons or entities whose notification is required by law or regulation, including:~~

~~(A) notification(s) required by notifications per OAC 340:100-3-35, in the case of when a person's death service recipient dies; and~~

~~(B) immediately notifying investigative authorities in the event of suspected abuse, or neglect, or exploitation, including:~~

- ~~(i) Office of Client Advocacy for members of the Homeward Bound class or persons residing in a public (ICF/MR) per OAC 340:2-3-33;~~
- ~~(ii) Adult Protective Services for adults other than those mentioned in unit (i) of this paragraph per Section 10-104 of Title 43A of the Oklahoma Statutes (43A O.S. § 10-104); or~~
- ~~(iii) Child Protective Services if the incident involves a child per 10 O.S. § 7103; and~~

~~(45) those persons as required by per OAC 340:100-5-57 to report 340:100-5-57.1 when reporting use of restrictive and intrusive behavior intervention(s) interventions.~~

- ~~(f) Program coordination staff reviews the incident report, describes in writing the action taken, signs, and dates the form.~~
- ~~(g) An original Form DDS 46, Incident Report, is kept in accordance with policy of the respective agency, and a legible copy is provided to the DDS case manager for filing in the case manager record.~~

340:100-3-37. Employee and provider rights and responsibilities [REVOKED]

~~(a) Resource center training. Staff of the public resource centers and the Robert M. Greer Center comply with the Title XIX training requirements found at 42 CFR, Parts 442, 483, 440.150 and licensure requirements promulgated by the Oklahoma State Department of Health in accordance with Section 1-1901 of Title 63 of the Oklahoma Statutes. Training regarding the use of any Level 4 procedures(s) must be renewed annually.~~

~~(b) Work attire. Employees are expected to dress appropriately according to their particular work assignment.~~

~~(1) Appropriate attire for particular assignments is defined by the facility or service area.~~

~~(2) Jewelry that may cause harm or injury to persons receiving services or staff is not worn.~~

~~(3) DDS employees who report for duty in inappropriate attire are placed on annual leave, if available, or work period adjustment, and are directed to change into appropriate attire and return for duty as soon as possible. Employees who refuse to comply with such directives, or who repeatedly report for duty in inappropriate attire, are subject to disciplinary action.~~

~~(4) The Department is not responsible for lost or damaged jewelry with specific exceptions applying to prescription eye glasses damaged as a result of client contact. Provisions for replacement of prescription eye glasses are addressed in OAC 340:2.~~

~~(e) Overtime. Services are not interrupted as a result of DDS employee absence.~~

~~(1) Sufficient staff are on the job to deliver services within ratios defined by Individual Plans and Federal ICF/MR standards.~~

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- (2) Staff are compensated for overtime work in accord with provisions of DHS rules and provisions of the Fair Labor Standards Act as amended.
- (3) ~~Volunteers are recruited to work overtime when necessary.~~
- (d) ~~Prohibition of paid services to family member. Family members are prohibited from assuming the role of a paid provider of habilitation or support services to a relative.~~
- (1) ~~Except as provided in paragraphs (2) and (3) of this subsection, relatives of individuals receiving Developmental Disabilities Services are not paid direct contract providers of covered services.~~
- (2) ~~The rules in this subsection do not prevent a relative of an individual receiving services from serving on the governing board of any provider agency or entity.~~
- (3) ~~The Director of the Department of Human Services or designee can waive the restrictions contained in paragraph (1) of this subsection if an individual's relative is:~~
- (A) ~~the only available provider of covered services due to geographical remoteness; or~~
- (B) ~~uniquely qualified to provide said services due to considerations such as language.~~
- (4) ~~The term relative includes a spouse, mother, father, brother, sister, or child (including those of in-law and step-relationship).~~

340:100-3-39. Pre-employment screening for community services workers

(a) **Legal basis.** Section 1025.1 et seq. of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.1 et seq.) requires ~~the Oklahoma Department of Human Services (OKDHS)~~ to establish and maintain a registry listing the names of community services workers against whom a final investigative finding of abuse, neglect, or exploitation, ~~as defined in Section per 43A O.S. § 10-103 of Title 43A of the Oklahoma Statutes, involving a person(s) with developmental disabilities service recipient,~~ has been made by ~~DHS~~ OKDHS or an administrative law judge. ~~(1) Providers of community services to persons with developmental disabilities service recipients:~~

- (1) ~~are required to conduct both a search of criminal history records search and a OKDHS Community Services Worker Registry (Registry) check prior to permanent employment of any community services worker; and~~
- (2) ~~The community services provider does must not hire, contract with, or use as a volunteer, a person whose name is listed in the Registry or who has a criminal background as described in this Section OAC 340:100-3-39(d)(1)(G).~~
- (b) **Applicability.** ~~The requirements in this Section set forth in OAC 340:100-3-39 apply to all community services providers who contract with, or are licensed or funded by, the Department of Human Services to provide residential or vocational services to persons with mental retardation or developmental disabilities, OKDHS or who contract with the Oklahoma Health Care Authority (OHCA) to provide residential or vocational employment services to individuals with mental retardation service recipients through the Developmental Disabilities Services Division (DDSD) Home and~~

~~Community-Based Waiver, except private ICFs/MR Services (HCBS) Waivers.~~

(c) **Definitions.** The following words and terms when used in this Section shall have the following meanings, unless the context clearly indicates otherwise:

(1) **"Community services provider"** means a community-based program, corporation, or individual person who contracts with, or is licensed or funded by, ~~the Department of Human Services to provide residential or vocational services to persons with mental retardation or developmental disabilities, OKDHS~~ or who contracts with OHCA to provide residential or employment services to individuals with mental retardation a service recipient through the Home and Community Based Waiver or the Alternate Disposition Plan Waiver, except a private ICF/MR DDSD HCBS Waivers.

(2) **"Community services worker"** means any person who is:

- (A) not a licensed health professional; and
- (B) who is employed by, or under contract with, a community services provider to provide:
- (A*i*) health-related services;
- (B*ii*) training; or
- (C*iii*) supportive assistance.

(3) **"Good cause"** ~~includes~~ means failure of a community services worker to make a timely response for reconsideration of a confirmed finding of abuse, neglect, or exploitation due to:

- (A) a death within the community services worker's immediate family;
- (B) hospitalization of the community services worker; or
- (C) ~~another an~~ an equally meritorious reason, to be determined within the sound discretion of the administrative law judge or other OKDHS staff of the Department authorized in accordance with this Section per OAC 340:100-3-39 to determine good such cause.

(4) **"Health related services"** means ~~those services assistance provided to persons with developmental disabilities a service recipient that include~~ includes, but is not limited to:

- (A) personal hygiene;
- (B) transferring;
- (C) range of motion;
- (D) supervision or assistance in activities of daily living; or
- (E) basic health supports nursing care, such as:
- (i) taking temperature, pulse, or respiration;
- (ii) positioning;
- (iii) incontinent care; or
- (iv) identification of signs and symptoms of disease.

(5) **"Supportive assistance"** means the service rendered ~~to persons with developmental disabilities which that is sufficient to enable the person service recipient to meet an adequate level of daily living including, but not limited to:~~

- (A) training;
- (B) supervision;
- (C) assistance in housekeeping;
- (D) assistance in the meal preparation of meals;
- ~~(E) assistance in the safe storage, distribution, or administration of medications; and~~
- ~~(FE) assistance in personal care and daily living skills as necessary for the health and comfort of the person service recipient.~~

(d) **Duties of community services providers.** ~~The responsibilities of a each provider are explained in this subsection.~~

(1) **Provider pre-employment responsibilities.** Each community services provider conducts a search of criminal history records ~~search~~ and a the Registry check for each potential employee who is not a licensed health professional and who will provide, for compensation or as a volunteer, on a full-time or part-time basis, health-related services, training, or supportive assistance to a ~~person(s) with developmental disabilities~~ service recipient. This Section requirement also applies to applicants for supervisory, management, or administrative positions, ~~if when~~ the applicant is to provide, on a full-time or part-time basis, supportive assistance, health-related services, or training to a ~~person(s) with developmental disabilities or mental retardation~~ service recipient. The provider:

(A) ~~Using~~ uses Form ~~DDS-39 06PE039E~~, Employment Application Supplement, ~~the provider to~~ formally ~~advises~~ advise each applicant of the:

- (i) ~~the~~ required search of criminal history records ~~search~~ and the Registry ~~check~~;
- (ii) ~~the~~ potential consequences of ~~these~~ background checks, including the provider's prohibition from hiring any person whose name appears ~~on in~~ the Registry or who has a prohibited criminal conviction, ~~in accordance with the rules in this Section per OAC 340:100-3-39(e)~~;
- (iii) ~~the~~ requirement that the community services worker's employment must be terminated if his or her name appears ~~on in~~ the Registry, even though the applicant's name may not have appeared ~~on in~~ the Registry at the time of application or hiring;
- (iv) ~~the~~ requirement to report all current and previous employers who provide services to the community services provider adults who are vulnerable; and
- (v) ~~the~~ fact that giving false information ~~in response to unit (iv) of this subparagraph regarding current and previous employers~~ results in termination of employment; and
- ~~(vi) the rights and responsibilities of a community services worker in the event of an investigation.~~

~~(B) The community services worker keeps a copy of Form DDS-39 and the provider retains the original in the community services worker's personnel file.~~

~~(CB) The community services provider contacts all previous employers engaged in delivery of services to~~

~~vulnerable adults who are vulnerable, as defined in Sections 43A O.S. § 10-103 of Title 43A of the Oklahoma Statutes, requesting information on allegations or findings of abuse, neglect, or exploitation;~~

~~(DC) If when~~ contacted by a potential employer, ~~each community service provider~~ gives accurate information regarding allegations of abuse, neglect, or exploitation that ~~have been were~~ reported to Adult Protective Services (APS) or Office of Client Advocacy, ~~which (OCA) and~~ are pending or confirmed;

~~(ED) Each provider~~ requests a criminal history records search from ~~the~~ Oklahoma State Bureau of Investigation (OSBI) prior to employment of, or offer of employment to, any applicant, except as provided in ~~subparagraph (D) of this paragraph~~ OAC 340:100-3-39(d)(1).

(i) The provider must secure the criminal history records search and cannot accept documents provided by the applicant.

(ii) If the provider uses a contractor to secure the criminal history records search, the contractor attaches the document received from ~~the~~ OSBI to any report given to the provider;

~~(FE) The provider~~ investigates discrepancies in the criminal record information received from ~~the~~ OSBI by completing the steps in this subparagraph.

(i) If discrepancies exist between criminal history information and information reported by the applicant, such as convictions not reported by the applicant, the provider secures from the applicant a written explanation of the discrepancy, ~~which that is then~~ sent to ~~the Department OKDHS~~ if the provider is requesting a waiver ~~under subsection per OAC 340:100-3-39(e) of this Section~~.

(ii) If ~~the~~ OSBI information reports inconclusive data, such as reporting ~~that~~ the case was referred to another law enforcement agency, the provider secures documentary evidence of the outcome;

~~(GF) A provider~~ may choose to make an offer of temporary employment to an applicant, pending the results of the OSBI criminal history records search.

(i) The provider submits a request for a criminal history records search to ~~the~~ OSBI within 72 hours of the applicant's acceptance of any offer of temporary employment.

(ii) Temporary employment of any applicant does not exceed 30 calendar days; and

~~(HG) If when~~ the OSBI search reveals that the applicant has been convicted, ~~or pled guilty,~~ or pled nolo contendere to any felony or to misdemeanor assault and battery or a felony, the provider does not hire or contract with the person and immediately cancels any temporary employment arrangement. If a waiver is requested ~~in accordance with subsection per OAC 340:100-3-39(e) of this Section~~, the community services worker is relieved of responsibilities working directly with service recipients until the

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- provider receives ~~the Department's~~ a written decision by OKDHS.
- (2) **Provider duties during an investigation.** Upon receiving notification of an investigation of an allegation of abuse, neglect, or exploitation involving an employee, the provider chief executive officer or designee:
- (A) ensures protection and ~~needed medical attention~~ the health and safety for any and all persons receiving services from the provider;
 - (B) notifies the community services worker, in a face-to-face conference, of the upcoming investigation; and
 - (C) explains the rights of the community services worker as ~~described in this Section~~, using Form DDS-59 06PE059E, Rights and Responsibilities of Community Services Worker in an Investigation of Abuse, Neglect, or Exploitation, before the community services worker is interviewed by the investigator, including:
 - (i) that notice of the outcome of the investigation is mailed to the community services worker's address as given on Form DDS-59-06PE059E; and
 - (ii) the community services worker's right to request due process in accordance with procedures given in the notice as mailed; and
 - (~~D~~) gives copies of the signed Form DDS-59 to:
 - (i) ~~the community services worker; and~~
 - (ii) ~~the investigator for inclusion with the report of the investigation.~~
- (3) **Provider responsibilities regarding due process procedures.** If an ~~employee(s)~~ employee of a provider is called as a witness in a hearing, the provider:
- (A) directs the ~~employee(s)~~ employee to attend the hearing to give testimony;
 - (B) ~~and~~ accommodates work schedules; and
 - (C) ~~If when~~ written records are required, ~~the provider~~ submits the required records or certified copies. Failure to comply with ~~this paragraph~~ these responsibilities may result in sanctions as ~~explained in per~~ OAC 340:100-3-27.
- (e) **Waiver of requirement not to hire based on criminal history records search.** If the criminal history records ~~check~~ search reveals a criminal background ~~that~~ the provider believes will not place a service recipient of services at risk of harm and will not affect the quality of services provided by the applicant, the provider may request a waiver from ~~the Department~~ OKDHS.
- (1) The provider sends a written request for a waiver to the ~~division administrator of DDS~~ director. The request includes:
- (A) the applicant's:
 - (i) full name;;
 - (ii) Social Security number; and
 - (iii) birth date of ~~the applicant~~ birth;
 - (B) a legible copy of ~~the~~ criminal history records search; and
- (C) an explanation of all factors or circumstances ~~which~~ the provider believes ~~should~~ must be considered.
- (2) A waiver is not granted, ~~in~~ under any ease circumstance, for employment of an applicant who has been convicted of, ~~or~~ pled guilty, or pled nolo contendere to:
- (A) a felony count of:
 - (i) aggravated assault and battery;
 - (ii) homicide;
 - (iii) murder;
 - (iv) attempted murder;
 - (v) rape;
 - (vi) incest; or
 - (vii) sodomy; or
 - (B) abuse, neglect, or ~~financial~~ exploitation of any person entrusted to the applicant's care.
- (3) No waiver is granted for offenses resulting in a ~~felony~~ conviction, ~~or~~ plea of guilty, or plea of nolo contendere to a felony that occurred less than five calendar years from the date of the request.
- (4) Factors considered in the ~~Department's~~ OKDHS decision to grant or deny a waiver include:
- (A) other convictions of the person;
 - (B) responsibility evidenced by the person since conviction;
 - (C) time lapse since the person's conviction;
 - (D) person's age upon conviction;
 - (E) ~~the~~ nature and underlying circumstances of the ~~offense(s)~~ person's offense;
 - (F) evidence of efforts made by the person toward rehabilitation, including job training or educational programs in which the person participated;
 - (G) ~~the~~ person's prior employment record; and
 - (H) ~~the~~ nature and location of the position the person seeks.
- (5) OKDHS:
 - (A) may grant a waiver for applicants who will provide services through DDS HCBS Waivers only upon concurrence by OHCA; and
 - (~~5B~~) ~~The Department~~ assumes no responsibility for the actions of ~~an individual~~ a person employed by a provider subsequent to a waiver ~~provided in accordance with this subsection~~. The provider indemnifies and holds ~~the Department~~ OKDHS harmless for any damages or attorney fees resulting from a claim that an employee of the provider subsequently abused, neglected, exploited, or otherwise injured a ~~person~~ receiving services service recipient.
- (f) **Rights of a community services worker.** During investigation of an allegation of abuse, neglect, or exploitation, any community services worker who is accused of abuse, neglect, or exploitation is entitled to:
- (1) be advised ~~by the chief executive officer or designee of the provider~~ of the nature of any allegation against ~~the~~ community services such worker;
 - (2) be interviewed by the investigator; ~~and~~ be allowed to give his or her position in relation to the ~~allegation(s)~~ allegation;

- (3) be advised of the substance of the evidence against him or her prior to making a statement to the investigator. The identity of persons reporting alleged abuse, neglect, or exploitation is not released during the investigation;
- (4) refuse, without penalty, to take a polygraph examination;
- (5) submit or supplement a written statement relating to the allegation(s)-allegation;
- (6) seek and receive advice concerning his or her rights and responsibilities in the investigation and review process; and
- (7) receive notice from ~~the Department~~ OKDHS of the outcome of the investigation.

~~(A)~~ The community services worker;

(A) provides a correct address at which he or she will to receive the notice-; and

(B) The community services worker is responsible to notify the DHS State Office of the investigating unit APS or OCA, as applicable, of any address change.

(g) Responsibilities of all community services workers worker. Any community services worker who is involved, either as a witness or as an alleged perpetrator accused caretaker, in the investigation of alleged abuse, neglect, or exploitation has the responsibility to:

- (1) prepare a written incident report;
- (2) be available for scheduled interviews;
- (3) respond fully and truthfully to the investigator's questions. A community services worker who believes that his or her answers to official inquiries concerning alleged abuse, neglect, or exploitation may incriminate him or her the worker in a criminal prosecution may discontinue the interview for that reason;
- (4) refrain from any action which that may interfere with the investigation, including any action which that may intimidate, threaten, or harass any person who has or may provide information relating to alleged abuse, neglect, or exploitation; and
- (5) appear at any hearing as requested by ~~the Department in accordance with unit~~ OKDHS per OAC 340:100-3-39(h)(6)(A) (vi) of subsection (h) of this Section.

(h) Procedures for notice and due process. ~~The procedures in this subsection allow notice and due process for the community services worker accused of abuse, neglect, or exploitation.~~

(1) Determination not to place in Registry. At any time during the notice and due process ~~provided in accordance with this subsection, the Department~~ OKDHS may determine ~~that~~ the placement of a community services worker's name ~~on in~~ the Registry is not warranted, despite a confirmed finding of abuse, neglect, or exploitation by ~~the investigating unit~~ APS or OCA, as applicable.

(A) ~~The Department~~ OKDHS may determine that the community services worker's name will not be placed ~~on in~~ the Registry if when the wrongful conduct:

(i) ~~the wrongful conduct~~ does not warrant placement ~~on in~~ the Registry using the "clear and

convincing evidence" standard applicable at the administrative hearing ~~provided by this subsection; or~~

(ii) ~~the wrongful conduct: (i)~~ did not result in, or create a substantial risk of, serious physical or emotional injury to a person receiving services service recipient; and or

(Hiii) ~~was is~~ not the result of intentional, willful, or reckless disregard for the health or safety of a person receiving services service recipient.

(B) When a determination ~~has been is~~ made in accordance with this paragraph that a community services worker's name is not to be placed ~~on in~~ the Registry, ~~the Department~~ OKDHS sends a notice to the community services worker informing the worker that his or her name will not be placed ~~on in~~ the Registry ~~despite the confirmed finding~~. A copy of the notice is sent to the community services provider who employed the community services worker at the time of the ~~incident(s) which incident that~~ resulted in the confirmed finding.

(2) Notification of DDS. ~~Divisions of the Department OKDHS divisions~~ responsible for investigating allegations of abuse, neglect, or exploitation, ~~in accordance with per OAC 340:2-3 and OAC 340:105-3 340:5,~~ send reports of investigations to the ~~division administrator of DDS~~ director or designee.

(3) Notification to provider. The ~~Division~~ OKDHS division responsible for the investigation notifies the provider when the investigative report reveals systemic administrative issues regarding:

(A) protection or safety of the person(s) receiving services service recipient; or

(B) ~~facility or provider~~ agency shortcomings.

(4) Notification to the community services worker. ~~Staff of the Department send~~ OKDHS sends written notice of the results of the investigation to the community services worker alleged to have committed abuse, neglect, or exploitation. The name of a the community services worker who has been a confirmed to have committed finding of abuse, neglect, or exploitation is added to the Registry when ~~the Department~~ OKDHS has sent a proper notice to the last known address of the community services worker, and the notice has been was returned as unclaimed or undeliverable. The notice:

(A) is sent within three working days of ~~the final approval of the investigative report receipt by OCA of the OKDHS determination to proceed with the Registry process~~. If the allegation is ruled out, the provider is also notified;

(B) is sent by certified mail, return receipt requested, if the investigation ~~has resulted in a finding of abuse, neglect, or exploitation;~~

(C) contains a summary of the evidence supporting the finding of abuse, neglect, or exploitation without identifying the complainant(s) complainant;

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(D) specifies that, if the community services worker desires to contest the finding, he or she submits a detailed, written statement with a request that ~~the Department~~ OKDHS issue a reconsideration decision reversing the finding;

(E) advises the community services worker that a reconsideration decision must be requested in writing, postmarked within ~~40~~ ten calendar days of ~~his or her~~ receipt of the notice; and

(F) notifies the community services worker that failure, absent good cause, to request a reconsideration decision within ~~40~~ ten calendar days, as evidenced by the date of his or her signature on the U.S. Postal Service return receipt card:

- (i) results in the finding becoming final;
- (ii) waives the right to further administrative or judicial review; and
- (iii) authorizes:
 - (I) entry of the community services worker's name ~~on~~ in the Registry; and
 - (II) disclosure ~~in accordance with subsection per OAC 340:100-3-39(I) of this Section~~ to any person requesting such information ~~in accordance with subsection per OAC 340:100-3-39(j) of this Section.~~

(5) **Reconsideration decision.** If the community services worker submits a timely request for a reconsideration decision, or if ~~the Department~~ OKDHS determines good cause for untimely filing, ~~the Department~~ OKDHS issues a reconsideration decision.

(A) The reconsideration decision ~~may~~:

- (i) ~~affirm~~ affirms the investigative report;
- (ii) ~~modify~~ modifies the investigative report;
- (iii) ~~reverse~~ reverses the investigative report; or
- (iv) ~~remand~~ remands the ~~finding~~ investigative report for further investigation; ~~and~~

(~~B~~) ~~The reconsideration decision~~ is issued within ~~five~~ ten working days of receipt of the request or, if applicable, the date of any determination of good cause.

(~~i~~) If the decision is to remand for further investigation, the investigation is completed within 15 working days of the decision to remand.

(~~ii~~) Upon completion of the supplemental investigation, ~~the Department~~ OKDHS notifies the community services worker within three ~~work~~ working days; ~~and~~

(~~C~~) ~~The Department's reconsideration decision~~:

(~~vi~~) states the basis for the ~~Department's~~ determination including, but not limited to, any investigative report, ~~Department~~ OKDHS records, or provider records deemed relevant; ~~and~~

(~~vii~~) specifically evaluates and comments upon the contents of the community services worker's written request; ~~and~~

(~~viii~~) is mailed to the community services worker by certified mail return receipt requested, postage prepaid.

(~~D~~) ~~If~~ When the reconsideration decision affirms or modifies the investigative report, ~~the Department~~ also OKDHS:

(i) ~~if the community services worker is aggrieved by the decision~~, notifies the community services worker that, ~~if he or she is aggrieved by the decision~~, ~~the community services worker~~ may request an administrative hearing;

(ii) states ~~that~~ a written request for hearing must be submitted by the community services worker to ~~the Department~~ OKDHS at a specified address and postmarked within ~~40~~ ten calendar days of receipt of the reconsideration decision, unless good cause is established. Receipt is deemed to occur on the date ~~he or she signed the community services worker signs~~ the U.S. Postal Service return receipt card; and

(iii) states ~~that~~ failure to timely request a hearing, absent a finding of good cause by an administrative law judge:

(I) results in the reconsideration decision becoming final;

(II) waives any right to either an administrative hearing or judicial review; and

(III) authorizes entry of the community services worker's name ~~on~~ in the Registry, and disclosure to any person requesting the information ~~in accordance with subsection per OAC 340:100-3-39(j) of this Section.~~

(~~E~~) ~~The reconsideration decision is mailed to the community services worker by certified mail return receipt requested, postage prepaid.~~

(6) **Notice of hearing.** ~~If~~ When the community services worker submits a timely written request for hearing, or upon the administrative law judge finding of good cause for a request that was not timely, ~~the Department~~ OKDHS sends a notice of hearing by certified mail, return receipt requested, postage prepaid within ~~40~~ ten working days of receipt of the request. (~~A~~) The notice is dated and states:

(~~A~~) ~~the name of the administrative law judge;~~

(~~B~~) ~~the time and date of the hearing, which that~~ must be held no ~~sooner~~ earlier than 15 calendar days and no later than 60 calendar days after the date of mailing of the notice;

(~~C~~) ~~the street and city address, and room number~~ where the hearing will be held;

(~~D~~) ~~that~~ failure of the community services worker to attend the hearing, absent a finding of good cause by an administrative law judge:

(I) results in the reconsideration decision becoming final;

(II) waives any right to either an administrative hearing or judicial appeal; and

~~(Hii)~~ authorizes entry of the community services worker's name ~~on in~~ the Registry, and disclosure to any person requesting the information ~~in accordance with subsection per OAC 340:100-3-39(j) of this Section;~~

~~(E)~~ that the community services worker may be represented by an attorney;

~~(F)~~ that requests by the community services worker or his or her attorney for witnesses, records, or both, relevant to the proceeding must be directed to the ~~Department OKDHS. The Department OKDHS~~ sends requests to the relevant ~~provider(s) provider, in accordance with paragraph per OAC 340:100-3-39(d)(3) of this Section, individuals per-~~sons, and affected ~~DHS unit(s) appropriate OKDHS divisions;~~

~~(G)~~ that a final proposed list of witnesses and summary of anticipated testimony must be submitted to the administrative law judge designated on the notice of hearing at least ~~10 ten~~ calendar days prior to any hearing;

~~(H)~~ that any final decision on the specific persons allowed to testify, the scope of direct testimony and cross-examination, and admissibility of exhibits will be within the sound discretion of the administrative law judge, except that all ~~Department OKDHS~~ and provider records pertaining to a finding of confirmed abuse, neglect, or exploitation are admissible;

~~(I)~~ that the community services worker or his or her attorney is allowed to cross examine witnesses called by the ~~Department's OKDHS~~ attorney, and the ~~Department's attorney who~~ is allowed to cross examine any witnesses called by the community services worker or his or her attorney; and

~~(J)~~ that, although the formal rules of evidence and procedure under ~~state Oklahoma~~ law are not controlling, the burden of persuasion and of initially coming forward with the evidence is on the ~~Department OKDHS~~ through its attorney, and the standard of proof is ~~by~~ clear and convincing evidence.

(7) **Hearing.** ~~The hearing is held in accordance with this paragraph.~~

(A) The hearing is:

(i) closed and all information presented therein is confidential; ~~and~~

(Bii) ~~The hearing is~~ tape recorded.

(CB) The administrative law judge ~~may affirm~~ affirms, ~~modify modifies,~~ or ~~reverse reverses~~ the reconsideration decision, or ~~may determine that de-~~termines the name of the community services worker, who has been confirmed as having engaged in neglect, ~~shall must~~ not be added to the Registry when the ~~act(s) act or omission(s) which~~ omission that is the basis for the confirmed finding:

(i) did not result in, or create a substantial risk of, serious physical or emotional injury to a ~~person receiving services service recipient; and or~~

(ii) was not the result of intentional, willful, or reckless disregard for the health or safety of a ~~person receiving services service recipient.~~

(DC) A written decision by the administrative law judge affirming, modifying, or reversing the reconsideration decision, or determining ~~in accordance with subparagraph (C) of this paragraph that, in spite of the neglect finding, per OAC 340:100-3-39(h)(7)(B),~~ the community services worker's name is not to be placed ~~on in~~ the Registry:

(i) is issued within 30 calendar days of the hearing;

(ii) is mailed to the community services worker by certified mail, return receipt requested, ~~not no~~ later than the first working day following the date the decision is signed by the administrative law judge;

(iii) contains findings of fact and conclusions of law;

(iv) notifies the community services worker that, if he or she is aggrieved by the decision, a judicial appeal, solely on the administrative record, may be initiated by filing a petition in the state Oklahoma district court with jurisdiction within 30 calendar days from the date the decision is signed by the administrative law judge, pursuant to Section 56 O.S. § 1025.3 of Title 56 and Section 75 O.S. § 318 of Title 75 of the Oklahoma Statutes; and

(v) states that a copy of any petition and summons filed in district court must be served on the ~~Department's Office of General Counsel OKDHS~~ Legal Division.

(i) **Disclosure requirements for the Registry.**

(1) The Registry information includes, but is not limited to:

(A) the community services worker's:

(i) full name;

(Bii) the ~~community services worker's~~ Social Security number; and

(iii) date of birth;

(CB) the date the community services worker's name was placed in the Registry; and

(DC) information on the final investigative finding or administrative law judge finding regarding the community services worker.

(2) The information ~~released from the Registry dis-~~closed includes only whether the person is listed ~~on in~~ the Registry. No other information related to the ~~allegation(s) allegation,~~ the investigation, or the evidence is ~~released~~ disclosed.

(3) The provider requesting Registry information on an applicant or employing a community services worker alleged to have committed abuse, neglect, or exploitation is notified when the community services worker's or applicant's name is entered ~~on in~~ the Registry. If more than one community services worker is named as an ~~alleged~~

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~~perpetrator~~ ~~accused caretaker~~, a separate letter is sent to the provider for each community services worker.

(j) ~~Requests for information from the Public access to Registry. Requests for information from the Access to the Registry must be made is available to DDS in writing the public through the OKDHS Web site, www.okdhs.org.~~

(1) ~~Requests for information from the Registry must include:~~

(A) ~~the full name of the community services worker;~~

(B) ~~the community services worker's birth date; and~~

(C) ~~the community services worker's Social Security number.~~

(2) ~~There is no charge for information from the Registry.~~

SUBCHAPTER 5. CLIENT SERVICES

PART 3. SERVICE PROVISIONS

340:100-5-15. Developmental Disabilities Services

Division (DDS) case manager activities

Each person receiving ~~waiver services through Developmental Disabilities Services Division (DDS) has Home and Community Based Services (HCBS) Waivers is assigned~~ a case manager who ensures that individual needs are met through linkage, assessment, brokerage, advocacy, and monitoring activities. ~~The case manager assists service recipients in gaining access to needed medical, social, educational, and other services and supports. The DDS case manager:~~

(1) ~~completes or arranges for necessary assessments to identify service recipient needs;~~

(2) ~~has overall responsibility for the development developing and updating of the service recipient's Individual Plan (IP), in accordance with per OAC 340:100-5-50 through 340:100-5-58, and Plan of Care;~~

(3) ~~describes service options in sufficient detail to assure that ensure the service recipient, or parent or guardian, as applicable, is able to make an informed choice regarding services;~~

(4) ~~assists service recipients in gaining access to needed medical, social, educational, and other services and supports;~~

(5) ~~coordinates and monitors services being delivered to determine their effectiveness in meeting the service recipient's needs of the service recipient;~~

(6) ~~has the authority to implement approved services prescribed in the service recipient's IP and to access emergency or crisis services, as defined by policy per OAC 317:40 and OAC 340:100; and~~

(7) ~~documents findings case management services in the Client Contact Manager (CCM).~~

340:100-5-19. Support services [REVOKED]

~~DDS provides through direct and contract services supports determined necessary by the Interdisciplinary Team (IDT) to sustain the individual in his or her current living arrangement or to facilitate transition to a less restrictive living arrangement.~~

(1) ~~The DDS subsidizes the cost of approved support services prescribed in an Individual Habilitation Plan (IHP) subject to eligibility, availability of resources, and a determination that the service is not available through another funding source.~~

(2) ~~Rates for all support services shall be established and approved by the Oklahoma Health Care Authority.~~

(3) ~~Client needs and strategies/rationale for specific support services are identified by the IDT and documented in the IHP.~~

(4) ~~Approved support services include:~~

(A) ~~Adaptive Equipment/Auxiliary Aids;~~

(B) ~~Architectural Modification Services;~~

(C) ~~Dental Examination/Prophylaxis;~~

(D) ~~Family Counseling Services;~~

(E) ~~Family Training Services;~~

(F) ~~Homemaker Services;~~

(G) ~~Respite Services;~~

(H) ~~Transportation Services;~~

(I) ~~Nutritional Services;~~

(J) ~~Occupational Therapy;~~

(K) ~~Physical Therapy;~~

(L) ~~Speech Pathology;~~

(M) ~~Audiology;~~

(N) ~~Psychology;~~

(O) ~~Other services as approved through future amendments to the HCBS Waiver and/or Oklahoma State Medicaid Plan.~~

(5) ~~Contract provider agencies are licensed, certified, or registered as required by Oklahoma statutes, regulatory authorities, and DDS contract provisions.~~

(6) ~~DHS or DDS purchases auxiliary aids and adaptive equipment for eligible individuals who are deaf when these cannot be more appropriately obtained from another resource [see OAC 340:100-1-2].~~

(7) ~~Residential and vocational contract providers are responsible for assuring that agency staff can communicate adequately with consumers on a day to day basis and can assist when needed in translation during social encounters, shopping, etc.~~

(8) ~~Support services do NOT include expenditures for rent, (vehicle or home) and/or the purchase of such recreation or leisure equipment as televisions, stereos, etc. unless otherwise approved by the Administrator of DDS or the Director of DHS or as required under terms of the Court Order in Homeward Bound et al vs. The Hissom Memorial Center.~~

340:100-5-22.6. Alternative group homes

(a) ~~Legal basis. Authority to operate alternative group homes is found in Section 1020 of Title 56 and Section 1175.6b of Title 22 of the Oklahoma Statutes (56 O.S. § 1020) and 22~~

O.S. § 1175.6b. Administrative and program requirements for alternative group homes, ~~in addition to those~~ are described in OAC 317:40-5-152 and OAC ~~340:100-5-22.6 and 340:100-6-12~~ are given in this Section.

- (b) **General information.** Alternative group homes:
- (1) ~~serve up to four individuals.~~
 - (1) ~~Service~~ service recipients who have:
 - (A) serious behavioral or emotional challenges or community protection issues in addition to mental retardation and require continuous supervision and assistance ~~in order~~ to remain in the community; or
 - (B) been charged with a felony ~~crime~~, determined by the district court ~~to be as incompetent to stand trial due to mental retardation and~~ dangerous, and placed by the district court in the custody of the public guardian; and
 - (2) ~~To ensure the safety of the service recipient and others, alternative group homes provide more restrictive measures than other community residential settings to ensure the safety of the service recipient and others.~~
- (c) **Provider approval criteria.** Providers In addition to requirements of OAC 340:100-6-12, prospective providers of alternative group home services must demonstrate a history of effective services and supports to persons with serious behavioral or emotional challenges or community protection issues. Provider approval requires review of historical information, if available, from Developmental Disabilities Services Division (DDSD) Quality Assurance Unit and ~~area office(s)~~ Area Office. The location of the alternative group home must be approved in writing by the DDSD director or designee prior to the implementation of services. Each prospective provider submits written documentation of:
- (1) history of services to ~~people~~ persons who present serious behavioral or emotional challenges or community protection issues, including:
 - (A) past experience;
 - (B) number of persons served;
 - (C) ~~the~~ provider's perspective on the greatest challenges in serving persons eligible for alternative group home services; and
 - (D) ~~the~~ provider's philosophy for service provision;
 - (2) fiscal information as requested to determine financial viability, including the anticipated budget related to the rate for alternative group home services;
 - (3) service provision plans, including:
 - (A) anticipated number of homes;
 - (B) location;
 - (C) floor plans;
 - (D) gender to be served;
 - (E) population to be served; and
 - (F) availability of psychological ~~services~~, psychiatric ~~services~~, and vocational services in the proposed location;
 - (4) plans for staffing and program coordination; and
 - (5) staff qualifications, including any additional training to be provided.
- (d) **Eligibility to receive services.** To be eligible for services in an alternative group home, the person must:

- (1) ~~have been placed~~ be in the custody of the public guardian ~~as provided in Section per 22 O.S. § 1175.6b or Section 1175.6c of Title 22 of the O.S.;~~ or
 - (2) meet the criteria for intermediate care facility for the mentally retarded (ICF/MR) level of care; and
 - (A) require 24-hour, on-site, awake staff supervision to ensure safety; and
 - (B) be found by the DDSD Community Services programs administrator ~~of community services~~ or designee to have serious behavioral or emotional challenges or community protection issues, such as:
 - (i) evidence of commitment of a sexually violent offense, ~~or sexually predatory act,~~ or a crime of sexual violence including, but not limited to:
 - (I) rape;
 - (II) lewd or indecent acts or proposals made to a child, ~~as defined in Section per 21 O.S. § 1123 of Title 21 of the O.S.;~~ or
 - (III) forcible sodomy, ~~as defined in Section per 21 O.S. § 888 of Title 21 of the O.S.;~~
 - (ii) a history of stalking or opportunistic behavior ~~which that~~ demonstrates a likelihood to commit a sexually violent or predatory act;
 - (iii) a documented pattern of acts of violence toward others;
 - (iv) experience ongoing, highly disruptive behavioral episodes that:
 - (I) are dangerous ~~as defined by Section 1175 of Title 22 of the O.S. per 22 O.S. § 1175.1;~~ and
 - (II) require close supervision and frequent intervention by staff;
 - (v) evidence of commitment of one or more violent offenses, such as:
 - (I) murder or manslaughter;
 - (II) attempted murder;
 - (III) arson;
 - (IV) assault;
 - (V) kidnapping; or
 - (VI) use of a weapon to commit a crime; or
 - (vi) severe ongoing self-injurious behavior.
- (e) **Services provided.** Services provided are designed to assist service recipients in acquiring, retaining, and improving ~~the~~ self-help, socialization, and adaptive skills necessary to reside successfully in a home and community-based setting.
- (1) Services include supports to meet ~~the needs of each service recipient~~ recipient's needs including, but not limited to:
 - (A) residential habilitation such as assistance with the acquisition, retention, or improvement ~~in~~ of skills related to activities of daily living, such as:
 - (i) personal grooming and cleanliness;
 - (ii) bed making and household chores;
 - (iii) eating and ~~the food~~ food preparation ~~of food~~; and
 - (iv) social and adaptive skills necessary to enable the service recipient to reside in a shared home;

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(B) program supervision and oversight including 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity and independence, while providing for supervision and safety; In addition to requirements in OAC 340:100-6-55, program coordination staff (PCS) must be provided that:

- (i) serves no more than 12 service recipients;
- (ii) ensures staffing levels meet the requirements of OAC 340:100-5-22.6(e)(1)(H); and
- (iii) ensures records are maintained per OAC 340:100-3-40;

(C) implementation of community protection precautions and individual program plans ~~as outlined in subsection per OAC 340:100-5-22.6(f) of this Section;~~

- (D) recreational and leisure activities, including individual and group activities;
- (E) assistance in money management;
- (F) health care services provided ~~in accordance with per OAC 340:100-5-26 and 340:100-5-26.3; and~~
- (G) medication administration ~~performed in accordance with per OAC 340:100-5-32; and~~
- (H) management of staffing levels to provide supervision that ensures the safety of the service recipient, community, staff, and other service recipients and meets the requirements of each service recipient's Individual Plan (Plan).

(i) An average of 14 hours of staffing per service recipient must be provided per billable day prior to filing a claim for habilitation training staff authorized in accordance with OAC 317:40-5-152.

(I) At least two awake staff must be on duty during hours when service recipients are in the home.

(II) This requirement may be reduced to one awake staff, when there is only one service recipient in the home.

(ii) Sufficient daytime staffing must be provided to:

(I) ensure adequate supervision in the home and community; and

(II) implement the Plan, except during the time the service recipient is in an employment, vocational, or day services program for which services have been authorized to provide the needed supervision, security, and support. All staff are trained in accordance with OAC 340:100-3-38.

(iii) At least two awake staff must be on duty during hours when service recipients are asleep.

(I) The requirement for two awake staff may be reduced to one staff with the approval of the Team when there are only one or two service recipients in the home.

(II) Staff on duty must be physically able and mentally alert to carry out the duties of the job.

(iv) The provider must:

(I) have staff available to provide necessary support and supervision when the service recipient needs to return from employment or other day services;

(II) provide activity options and supervision during all periods of time when the service recipient is not participating in authorized employment activities; and

(III) ensure effective transition and coordination of supervision between alternative group home and employment programs or other authorized absences from the alternative group home program.

(2) In addition to the services listed in paragraph in OAC 340:100-5-22.6(e)(1) of this subsection, services for wards of the public guardian are designed to ensure the service recipient is not dangerous to self or others.

(f) **Alternative group home program requirements.** In addition to compliance with applicable rules of the Oklahoma Department of Human Services (OKDHS) and Oklahoma Health Care Authority (OHCA) and DDSD rules, alternative group homes meet the requirements in this subsection. The provider agency ensures that:

(1) staff ~~implement~~ implements security precautions protecting the service recipient, ~~and~~ neighbors, children, ~~vulnerable~~ adults who are vulnerable, animals, and others;

(2) staff ~~implement~~ implements outcomes and action steps detailed in the Plan to assist service recipients to function safely in the community and avoid criminal activity;

(3) collaboration and coordination occur with DDSD staff, employment providers, therapists, and other ~~agencies~~ entities and individuals persons, such as law enforcement, corrections officers, schools, employers, mental health workers, and, when appropriate, the public guardian ~~if the individual has been placed in the custody of the public guardian;~~

(4) program designs and behavior support practices beyond those ~~contained~~ specified in this Section OAC 340:100-5-22.6 comply with OAC 340:100-5-50 through 340:100-5-58;

(5) written agency policies comply with ~~DDSD~~ OKDHS and OHCA rules;

(6) effective security and supervision of service recipients in the residence and ~~in the community is~~ are provided;

(7) contingency plans are developed and implemented for:

(A) emergency relocation of a service recipient who has created a danger or who is in danger;

(B) emergency staffing in the event changes are required to protect staff or others;

(C) general emergencies requiring evacuation of the ~~whole entire~~ home, such as fire or weather emergencies, ~~as addressed in per OAC 340:100-5-22.1~~ 340:100-6-45; and

(D) elopement;

(8) legal and court requirements are followed, including adherence to state Oklahoma laws governing registered sexual offenders;

(9) the health care coordinator or other knowledgeable staff ~~member~~ accompanies ~~each~~ the service recipient to ~~a~~ each medical or psychiatric appointment, taking current data summaries that indicate the rate of occurrence of medication-responsive symptoms or behaviors over the last one to three months. For visits to the physician prescribing psychotropic ~~medication(s)~~ medication, the summary covers symptoms or behaviors listed on ~~OKDHS Form DDS-67 06HM067E~~, Semi-annual Psychotropic Medication Review;

~~(10) staff meet training requirements of OAC 340:100-3-38;~~

~~(11) specific offense patterns are considered and addressed when determining appropriate program locations. In addition to the requirements of OAC 340:100-6-12 and OAC 340:100-6-30, the location of the home must be approved in writing by the DDSD director or designee prior to implementation of services;~~

~~(12) cabinets are kept locked if they contain any knives or other sharp objects that could may be used as weapons or any items specifically identified by the Team as dangerous;~~

~~(13) staff provide provides arm's-length supervision to each service recipient when outside the home unless another supervision pattern is specifically described in the Plan and approved by designated DDSD State Office staff;~~

~~(14) door and window alarms are used;~~

~~(15) a fenced the yard is fenced with a locked gate, unless the requirement for a locked gate is waived in writing by the DDSD director or designee; and~~

~~(16) other necessary restrictive procedures as detailed in the Plan are implemented, that may include:~~

- ~~(A) restricted views from; or into; windows, doors, and other openings;~~
- ~~(B) restricted access to certain areas; and~~
- ~~(C) in the case of for wards of the public guardian, restrictions deemed necessary to keep the service recipient and public safe.~~

(g) **Weapons.** Dangerous or deadly weapons are not permitted in the alternative group home or on the premises. ~~Provider agency staff~~ Providers are prohibited from assisting any service recipient to obtain or possess dangerous or deadly weapons. ~~Dangerous or deadly weapons include including,~~ but are not limited to:

- (1) guns, BB guns, air rifles, or other firearms;
- (2) crossbows;
- (3) paint guns;
- (4) arrows;
- (5) explosives;
- (6) stun guns; and
- (7) knives, except cooking and eating utensils.

(h) **Prohibited substances.** Illegal substances and alcohol are not permitted in the alternative group home.

(i) **Medicaid SoonerCare eligibility.** The service recipient and guardian, with necessary support from the provider agency,

establish and maintain Medicaid SoonerCare eligibility, if possible.

(j) **Natural supports. Individuals Persons** who agree to provide natural supports to a service recipient living in an alternative group home ~~are responsible to~~ must:

(1) work with the Team to develop a schedule, support strategies, or other ~~agreement(s)~~ agreement for support. Each Plan contains a description of any natural support to be provided ~~which that~~ ensures the safety and welfare of the service recipient and the community. No arrangement can be made for natural supports that ~~would~~ violate existing court orders, security ~~agreements~~ arrangements, or individual planning for community protection the Plan;

(2) keep commitments made regarding supports; and

(3) document or report to the program coordinator or DDSD case manager regarding the supports provided.

(k) **Refusal to participate.** If a service recipient or legal guardian refuses to participate in service delivery as described in the Plan:

- (1) the provider:
 - (A) continues to implement the Plan as written; and
 - ~~(2B) the provider~~ immediately notifies the DDSD case manager of the need for a Team meeting;
- ~~(32) the DDS~~ case manager takes immediate action to convene the Team to address the situation; and
- ~~(43) steps given~~ in OAC 340:100-3-11 are followed.

(l) **Record keeping.** In addition to ~~the~~ requirements of OAC 340:100-3-40, records of service recipients must include:

- (1) documentation of the registration of the service recipient with appropriate law enforcement authorities, if required, ~~as well as~~ and documentation of subsequent notification to DDSD of registration;
- (2) documentation of all agreements or plans with other agencies or individual persons who support the service recipient, including guardian and family members, ~~which must include that specifies~~ requirements for supervision of the service recipient when staff is not present;
- (3) documentation of any refusal by the service recipient to follow conditions of the Plan, Protective Intervention Plan, or treatment recommendations of treatment professionals; and
- (4) Form ~~DDS-55 06CB055E~~, Monthly Summary of Physical Management Procedures Restrictive/Intrusive Procedure Usage, ~~as required by per~~ OAC 340:100-5-57.1 ~~which is submitted for each home to the DDS~~ area positive support field specialist by the 10th day of the following month.

(m) **Transportation.** Providers of alternative group home services must ensure ~~that~~ transportation is:

- (1) available as needed for medical emergencies, appointments, day programs, and community activities ~~in accordance with per~~ OAC 317:40-5-103; and
- (2) supervised ~~as described in this Section per~~ OAC 340:100-5-22.6 in accordance with ~~the needs of~~ each service recipient recipient's needs.

~~(n) DDS~~ initiated transition. ~~The DDS programs administrator for community services or designee may initiate the transition process for a person receiving alternative group~~

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~~home services who can be effectively served in another residential environment.~~

~~(en) **Transition.** Teams plan for transition of service recipients to appropriate services when it is determined the alternative group home program is no longer necessary.~~

~~(1) Within three months of the service recipient's admission to an alternative group home, the Team develops reasonable criteria for the service recipient's move to a less restrictive environment that are:~~

~~(A) included in a written plan submitted to designated DDSD State Office staff; and~~

~~(B) reviewed at least annually by the Team.~~

~~(2) All transitions from alternative group homes must be approved by designated DDSD State Office staff. State Office residential Residential Unit staff may adjust the transition date if necessary.~~

~~(o) **DDSD-initiated transition.** DDSD Community Services programs administrator or designee may initiate the transition process for a person receiving alternative group home services who can be effectively served in another residential environment.~~

SUBCHAPTER 6. GROUP HOME REGULATIONS

PART 1. GENERAL PROVISIONS

340:100-6-1. Purpose [REVOKED]

~~The purpose of this Subchapter is to establish licensure requirements and otherwise implement and supplement the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act.~~

340:100-6-2. Definitions Legal base, purpose, and definitions

~~(a) **Legal base.** Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes, Group Homes for Persons with Developmental or Physical Disabilities Act, mandates Oklahoma Department of Human Services (OKDHS) to establish licensure requirements for such group homes and to otherwise implement the requirements of this Act.~~

~~(b) **Purpose.** OAC 340:100-6 sets forth licensure requirements, standards, and provisions for group homes for persons with developmental or physical disabilities.~~

~~(c) **Definitions.** The following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~(1) **"Abuse"** means causing or permitting:~~

~~(A) the intentional infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish; or~~

~~(B) the deprivation of food nutrition, clothing, shelter, or medical health care, or other care or services without which serious physical or mental injury is~~

~~likely to occur to a resident of a group home by a caretaker or other person responsible for providing these services; and~~

~~(C) any sexual assault inflicted on to a resident of a group home.~~

~~"Administration" means the removing of a single dose of medication from a labeled container and preparing that dose for distribution.~~

~~"Behavior Management" means techniques designed to influence existing behavior in some predetermined manner, replacing maladaptive or problem behaviors with behaviors that are adaptive and appropriate.~~

~~"Dispensing" means transferring one or more doses of medication from one labeled container to another labeled container.~~

~~(2) **"Administrator"** means the person designated by the provider who has authority and responsibility for the programs and operation of a group home.~~

~~(3) **"Advocate"** means an adult designated in writing selected by the resident to assist the resident in exercising the rights of such resident.~~

~~(4) **"Exploitation"** means the unjust or improper use of the resources of a person resident of a group home for the profit or advantage, pecuniary or otherwise, of another person other than such resident through the use of:~~

~~(A) undue influence;~~

~~(B) coercion;~~

~~(C) harassment;~~

~~(D) duress;~~

~~(E) deception;~~

~~(F) false representation; or~~

~~(G) false pretense.~~

~~(5) **"Group home for persons with developmental or physical disabilities"** means any establishment:~~

~~(A) for not more than 12 residents who:~~

~~(i) are 18 years of age or older; and~~

~~(ii) have developmental or physical disabilities;~~

~~(B) that offers or provides supervision, residential accommodations, food service, and training and skill development opportunities designed to lead to increased independence of the residents and supportive assistance to any of the residents requiring supportive assistance; and~~

~~(C) that is not:~~

~~(i) a residential care home;~~

~~(ii) a nursing facility;~~

~~(iii) an assisted living facility;~~

~~(iv) a home in which agency companion services or specialized foster care is provided; or~~

~~(v) a home owned or leased by the service recipient or his or her legal guardian.~~

~~(6) **"Indecent exposure"** means forcing or requiring a resident of a group home to:~~

~~(A) look upon the body or private parts of another person or upon sexual acts performed in the presence of the resident; or~~

(B) touch or feel the body or private parts of another.

"Monitor" means watch, observe, check and keep track of for a special purpose.

(7) "Neglect" means:

(A) a failure to provide protection for a person resident of a group home who is unable to protect his or her own interest interests;

(B) the failure to provide a resident of a group home with adequate shelter, nutrition, health care, or clothing; or

(C) the harming or threatening with harm negligent acts or omissions that result in harm or the unreasonable risk of harm to a resident of a group home through the action, or inaction, or lack of supervision by either another individual or through the person's own action or inaction because of his/her lack of awareness, incompetence, or incapacity, which has resulted or may result in physical or mental injury a caretaker providing direct services.

"Owner" means the provider of group home services.

"Personal care" means assistance with meals, dressing, movement, bathing or other personal needs, or general supervision of the physical and mental well-being of a person who is currently unable to maintain a private, independent residence or has limited abilities in the managing of his/her person, whether or not a guardian has been appointed for such person.

"Physically handicapped" means a condition that causes the restricted use of the extremities by an individual or affects other bodily functions of an individual and requires the specialized training, habilitation or rehabilitation services provided by a group home.

(8) "Physical disability" means a condition that:

(A) causes restricted use of extremities by or affects other bodily functions of a person; and

(B) requires specialized training or habilitation or rehabilitation services provided by a group home.

(9) "Provider" means a person, corporation, partnership, limited liability company, association, or other entity which operates that contracts with OKDHS Developmental Disabilities Services Division (DDSD) or Oklahoma Health Care Authority or is licensed to operate a group home under contract with the Department, or to whom a license is issued for operation of a group home persons with developmental or physical disabilities.

(10) "Resident" or "service recipient" means a person residing receiving services in a group home for developmentally disabled or physically handicapped persons due to a with developmental disability or physical handicap disabilities.

"Self administration" means the administration of resident's medication by the resident with periodic staff review.

(11) "Service recipient" or "resident" means a person receiving services in a group home for persons with developmental or physical disabilities.

(12) "Sexual abuse" means:

(A) oral, anal, or vaginal penetration of a resident of a group home by or through the union with the sexual organ of a caretaker or other person providing services to the resident, or the anal or vaginal penetration of a resident by a caretaker or other person providing services to the resident with any other object;

(B) for the purpose of sexual gratification, the touching, feeling, or observation of the body or private parts of a resident of a group home by a caretaker or other person providing services to the resident; or

(C) indecent exposure by a caretaker or other person providing services to the resident of a group home.

(13) "Sexual exploitation" means, but is not limited to, a caretaker causing, allowing, permitting, or encouraging a resident of a group home to engage in prostitution or in the lewd, obscene, or pornographic photographing, filming, or depiction of the resident as those acts are defined by Oklahoma law.

"Supervision" means the provision of on-site staffing at times when the residents are in the group home or on the premises of the group home.

(14) "Supportive assistance" means the service rendered to any person a resident of a group home that is sufficient to enable the person resident to meet an adequate level of daily living. Supportive assistance includes including, but is not limited to:

- (A) training;
- (B) supervision;
- (C) assistance in housekeeping;
- (D) assistance in meal preparation of meals;
- (E) assistance in the safe storage, distribution and administration of medications; and
- (F) assistance in personal care as activities of daily living necessary for the health and comfort of such person.

"Transfer" means a change in location of living arrangements of a resident from one group home to another group home.

(15) "Verbal abuse" means the use of words, sounds, or other communication including, but not limited to:

- (A) gestures;
- (B) actions; or
- (C) behaviors by a caretaker or other person providing services to a resident of a group home that is likely to cause a reasonable person to experience humiliation, intimidation, fear, shame, or degradation.

PART 3. BASIC LICENSURE STANDARDS

340:100-6-10. License or contract required

(a) It shall be is unlawful for any person or organization to operate a group home without a license from the Oklahoma Department of Human Services (OKDHS). However, providers of group home services that Providers who have a current contract to provide:

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- (1) ~~group home services with the OKDHS Developmental Disabilities Services Division shall be (DDSD); or~~
(2) ~~Home and Community-Based Waiver group home services with Oklahoma Health Care Authority (OHCA) are deemed to be in compliance with standards promulgated by the Commission for Human Services and as such shall be exempt from licensure licensed.~~
- (b) ~~All licenses shall~~ A license to operate a group home must include, but is not be limited to:
- (1) ~~the maximum bed capacity for which it the license is granted;~~
 - (2) ~~the kind of program the licensee is certified to operate;~~
 - (3) ~~the date license was issued;~~ and
 - (4) ~~the expiration date of the license;~~ and
 - (5) ~~address of the home for which the license is issued.~~
- (c) ~~The~~ A license shall be is issued only for the premises named on the application and shall not be is neither transferable or nor assignable.
- (d) DDSD Community Services staff maintain a record of each group home deemed licensed, including:
- (1) maximum bed capacity;
 - (2) type of group home operated; and
 - (3) address of group home.

340:100-6-11. Types of licenses

- (a) **Regular license.** ~~The group home license shall be for a 12 month period expiring one year expires 12 months from the date of issue and may be issued upon application, and inspection, and payment of the license fee.~~
- (b) **Probationary license.** ~~If the applicant for a group home license has not been previously licensed, or if the group home is not in operation at the time application is made, the Department shall issue a probationary license, or a probationary contract.~~
- (1) ~~A probationary license or contract shall be valid for 120 days unless suspended or revoked sooner.~~
 - (2) ~~Within 30 days prior to the expiration of the probationary license or probationary contract, the Department shall completely inspect the group home. If the home meets the applicable requirements, a regular license or contract for the remainder of the fiscal year shall be issued. If the home is not in compliance with the provisions of the Group Homes for Developmentally Disabled or Physically Handicapped Persons Act and the standards and requirements established by the Department, the license or contract shall be denied.~~
- (c) **Conditional license.** ~~The Department OKDHS may issue a conditional license or contract to any group home in which it finds that a violation exists. The issuance of a conditional license or contract shall revoke revokes any license held by the group home.~~
- (1) ~~Prior to the issuance of a conditional license or contract, the Department shall review OKDHS:~~
 - (A) ~~reviews and approve approves a written plan of correction;~~
 - (B) ~~The Department shall specify specifies the violations which that prevent full licensure or contracting~~

~~and shall establish establishes a time schedule for correction of the deficiencies; and~~

(C) ~~Written sends notice of the decision to issue a conditional license shall be sent to the provider, together with the proposed plan of correction. The notice shall inform informs the provider of the right to an appeal in accordance with per OAC 340:100-3-27.~~

(2) ~~A conditional license or contract shall be issued for a period specified by the Department, but in no event for more than one year. In the alternative or in addition to a conditional license or contract, the Department may withhold vendor payments due a group home until corrections are made or a plan of correction for all deficiencies is approved by the Department, or may initiate other action as defined in OAC 340:100-3-27.~~

(2) OKDHS provides notice and due process for the holder of a conditional license per Section 1430.17 of Title 10 of the Oklahoma Statutes.

340:100-6-12. Application for group home license, or license renewal, or contract

- (a) Any ~~individual person~~ or organization desiring to operate a group home ~~shall must~~ request a licensure packet from: Group Home Licensure, Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD), Group Home Licensure, P.O. Box 25352, Oklahoma City, OK 73152 73125.
- (b) An applicant for license, ~~or license renewal thereof, or contract to operate a group home shall must~~ submit to ~~the Department OKDHS~~ a completed application along with the \$25.00 license fee and documents required by ~~the Department OKDHS~~ to determine ~~that whether~~ the applicant:
- (1) ~~is 21 years of age or older and of reputable and responsible character, and otherwise;~~
 - (2) ~~demonstrates the skill and fitness to provide the necessary services;~~
 - (3) ~~In addition, the applicant shall have has appropriate business or experience; and~~
 - (4) ~~has professional experience in dealing with the type of residents in the home population to be served. The license fee for \$25.00 is not refundable.~~
- (c) ~~A license fee of \$20.00 shall accompany any application for modification of a license.~~
- (d) ~~An application for license or renewal shall include a copy of all agreements with the professional consultants utilized to provide care and treatment of the residents.~~
- (e) An application for a license ~~or contract~~ to operate a group home ~~shall provide must include~~ documentation that the State Fire Marshal state fire marshal or his/her representative has inspected and approved the home. A contract provider who wishes to open an additional group home must also provide this documentation.
- (1) ~~The After the initial state fire marshal inspection, each group home must be inspected by the State Fire Marshal every three years, or authorized representative annually and more often upon request from DDSD, and found to be in compliance with fire safety regulations prior to reissuance re-issuance of a license or contract.~~

(2) All group home inspections are subject to state fire marshal fees, citations, and penalties.

(fd) The following shall be renewed Prior to opening and annually thereafter, the provider must obtain for each group home a licensed:

- (1) licensed plumber or municipal building inspector's report; and
- (2) licensed electrician or municipal building inspector's report;

(ge) An approval letter from the local zoning authority shall must accompany all first-time initial license applications or contractor requests for each particular address.

(f) No person who is ineligible for employment as a community services worker, per OAC 340:100-3-39, is eligible to:

- (1) be licensed; or
- (2) receive a contract to become a provider. If the applicant, licensee, or contractor is a firm, partnership, limited liability company or corporation, the applicant is not eligible to:

- (A) be licensed; or
- (B) receive a contract if any:
 - (i) member of the firm;
 - (ii) major member of the limited liability company or manager;
 - (iii) major partner of the partnership; or
 - (iv) officer or major stockholder of the corporation is ineligible for employment as a community services worker.

340:100-6-13. Inspections

(a) Each home licensed as a group home shall must be periodically inspected at least annually by a duly appointed representative of the Oklahoma Department of Human Services (OKDHS). At least one inspection per group home must be unannounced.

(b) Any holder of or applicant for a license shall be or contract is deemed to have given consent to any authorized employee or agent of the Department OKDHS to enter and inspect the home.

(c) When a notice of violation is sent to a home as a result of an inspection, the home has ten days after receipt to prepare and submit a plan of correction. The plan shall include a fixed time period, not in excess of 30 calendar days, within which violations are to be corrected. An additional 30 days may be requested and approved from the Department.

(d) The provider receives results of the inspection and corrects identified concerns in accordance with OAC 340:100-3-27.1.

340:100-6-14. Sanctions

(a) The Oklahoma Department of Human Services (OKDHS) may deny, suspend, revoke, deny, or refuse to renew any group home license found to be in violation of the Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes (10 O.S. § 1430.1 et seq.), Group Home Homes for Persons with Developmental or Physical Disabilities Act, or the OKDHS rules of the Commission for Human Services. As provided in

~~Section 1430.3 of Title 10 of the Oklahoma Statutes on the following grounds:~~

- (1) ~~the violation of any provision of the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act, or any regulation issued pursuant thereto;~~
- (2) ~~the act of permitting, aiding, or abetting the commission of any illegal act in the home;~~
- (3) ~~conduct determined to be detrimental to the welfare of the residents of the licensed home;~~
- (4) ~~refusal to permit entry by Department personnel for on-site inspection;~~
- (5) ~~insufficient financial or other resources by the licensee to provide adequate care or treatment of the residents of the home; and~~
- (6) ~~failure of the licensee to correct conditions in the home as required in a notice of violation and plan of correction.~~

(b) ~~As authorized by Title 63, Per 10 O.S. 1991, Section 1-818.32A § 1430.32, civil penalties per each day of violation of the provisions of the Group Homes for Developmentally Disabled or Physically Handicapped Persons Act shall be not more than \$100.00 per day. The maximum civil penalty shall not any person determined by OKDHS to have violated any provision of 10 O.S. § 1430.1 et seq. or any OKDHS rule or court order issued pursuant thereto may be liable for an administrative penalty of not more than \$100 for each day the violation continues. The maximum administrative penalty cannot exceed \$10,000.00 10,000 for any related series of violations.~~

(c) OKDHS may:

- (1) withhold payments due for group home services until corrections are made or a plan of correction for all deficiencies is approved by OKDHS; or
- (2) initiate other action per OAC 340:100-3-27.2.

340:100-6-15. Records and reports

(a) Every provider of group home shall conspicuously post for display in an area of its offices accessible services:

- (1) makes available to residents, employees, and visitors, the following:
 - (1A) it's the current license or contract to provide group home services between the provider and Oklahoma Department of Human Services (OKDHS) or Oklahoma Health Care Authority (OHCA);
 - (2B) residents' resident rights as listed in this Subchapter per OAC 340:100-6-95;
 - (3C) a description, provided by the Department, of complaint OKDHS-approved grievance procedures, established under the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act and the including name, address, and telephone phone number of the local grievance coordinator and of a person authorized by the Department OKDHS to receive complaints regarding potential contract violations; and

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- (4D) a copy of any order currently in effect pertaining to the facility group home issued by the Department or a court, which is currently in effect; and
- (5) a list of materials available for public inspection.
- (b2) Every group home shall retain retains for public inspection:
 - (1A) a complete copy of every inspection report of the group home received from the Department OKDHS during the past three years with resident-identifying information removed;
 - (2B) a copy of every order correspondence pertaining to the group home issued by the Department OKDHS, OHCA, or a court during the past three years with resident-identifying information removed;
 - (3C) a description of the services provided by the group home and the rates charged for those services; and items or services for which a resident may be separately charged;
 - (4D) a copy of the statement of ownership, including names and addresses of board members and major stockholders; and
 - (5) a report of personnel who are licensed, certified, or registered and employed or retained by the group home who are responsible for resident care; and
 - (6E) a complete copy of any current license or contract or agreement between the group home provider and the Department for the care, treatment, habilitation of residents of the group home OKDHS or OHCA.
- (eb) Reports of communicable disease shall must be made by the group home provider in accordance with 63 O.S. 1991, Sections Section 1-502, et. seq. of Title 63 of the Oklahoma Statutes.
- (d) The Department of Human Services' area manager shall be notified of all incidents pertaining to fire, storm damage, death, residents missing, or utilities failure for more than four hours, and other critical incidents. Notice shall be made no later than the next working day.
- (e) An evacuation plan shall be developed for each group home. Fire drills shall be conducted at least quarterly.
- (f) The facility shall have a written plan for temporary living arrangements in case of fire, climatic conditions that warrant evacuation and/or other natural disasters that may render the facility unsuitable.
- (c) Service recipient records are maintained in accordance with OAC 340:100-3-40 and 340:100-3-40.1.

340:100-6-16. Resident records [REVOKED]

- (a) All current documents which relate to the residents must be kept in the group home. Other records may be kept in the central business office, or other location, but must be made available upon request by the Department.
- (b) Every resident record shall include, as a minimum, the following information:
 - (1) resident's name and date of birth;
 - (2) written authorization for emergency medical/dental service form signed by the resident or guardian;

- (3) medical summary to include medications and dosages;
- (4) the name, address and telephone number of resident's physician;
- (5) the name, address and telephone number of resident's dentist;
- (6) a record of the resident's illness, accidents and unusual occurrences while a resident of the facility;
- (7) resident's legal status;
- (8) current Individual Habilitation Plan and progress reports; and
- (9) an accounting of the resident's funds received and/or distributed by the group home.
- (e) All persons having access to the records shall strictly adhere to confidentiality as outlined in Group Homes for Developmentally Disabled and Physically Handicapped Persons Act.
- (d) Resident records shall be maintained in a lockable container or a specific lockable area.
- (e) All records and information regarding a resident are confidential and shall be released only in accordance with this Subchapter and to individuals or agencies who have proper authorization from the resident/legal representative.

340:100-6-17. Resident council [REVOKED]

- (a) Each group home shall establish a resident's advisory council. The group home administrator shall designate a member of the group home staff to coordinate the establishment of and render assistance to the council. No employee or affiliate of the home shall be a member of the council.
- (b) The council shall consist of not less than three or 50% of the residents or residents' family, whichever is lesser.
- (c) The council shall meet at least monthly.
- (d) A staff member shall assist in preparing a report of each meeting and make a copy available to the residents, the administrator, and staff.
- (e) Reports of the council meetings shall be maintained in the home by the house manager.
- (f) Names of all residents attending the meeting shall be recorded in the reports.
- (g) The resident's advisory council may present complaints to the Department on behalf of a resident and shall be a forum for:
 - (1) obtaining and disseminating information; and
 - (2) soliciting and adopting recommendations for group home programming and improvements and to strengthen the home's policies and procedures as they affect resident's rights and home responsibilities.

340:100-6-18. Complaints

- (a) Any person who has personal knowledge or substantial specific information that the Act, Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes or rules in this Subchapter, or a federal certification rule applicable to a group home OAC 340:100-6 may have been violated, may register a complaint and request an investigation. The complaint may be is made to the appropriate DDSD area manager or the Oklahoma Department of Human Services Developmental Disabilities

Services Division (DDSD) State Office Quality Assurance Unit in accordance with OAC 340:100-3-27.1. DDSD takes steps to protect the identity of the complainant, provided that such complainant is:

- (1) a service recipient;
- (2) a representative of a service recipient; or
- (3) an employee of a group home.

(b) A complaint may be made in writing, by telephone, or in person.

(c) An oral complaint shall be reduced to writing by the Department.

(d) Substance of the complaint shall be provided to the provider or administrator of the home no earlier than the commencement of the on site investigation of the complaint. A written copy can be obtained upon request to the Department.

(e) Unless otherwise directed by a court of law, the complainant's name shall not be revealed.

(f) Provided that any person who willfully or recklessly makes a false request or a report without a reasonable basis in fact for such a request under the provisions of the Act shall be liable in a civil suit for any actual damages suffered by a group home so requested to be investigated for any punitive damages set by the court or jury which may be allowed in the discretion of the court or jury when deemed proper by the court or jury.

(g) In all cases, the Department shall inform the group home and the complainant, unless otherwise indicated by the complainant, of its findings within ten days of its determination. The notice of such findings shall include a copy of the written determination, the correction order, if any, the warning determination, the correction order, if any, the warning notice, if any, and the state licensure or federal certification for, or both, on which the violation is listed.

340:100-6-19. Abuse, and neglect, and exploitation

(a) ~~The~~ Each group home shall have provider must implement a written policy statement that expressly prohibits the neglect and abuse, neglect, and exploitation, per Section 10-103 of Title 43A of the Oklahoma Statutes, of the individuals it serves service recipients.

(b) Any individual person who suspects abuse, or neglect, or exploitation of a resident shall service recipient must report the matter immediately to the Adult Protective Services office Oklahoma Department of Human Services (OKDHS), 1-800-522-3511, or local OKDHS office.

(c) A manager, operator, administrator, or The group home provider who suspects abuse, or neglect, shall immediately act to rectify the problem and make a report of the incident and its correction to the Department no later than the next working day or exploitation must take steps necessary to protect the health, safety, and welfare of the residents.

(d) Any individual who is found by the Adult Protective Services office or the Office of Client Advocacy to be negligent or physically or verbally abusive to residents shall be immediately relieved of his/her responsibilities.

(e) The group home shall provide staff training in the identification of abuse and neglect and the agency's policies and procedures concerning the same. Verification of the provision

of the training shall be written, signed by staff, and retained in personnel files.

(d) Each group home provider follows requirements of OAC 340:100-3-39 regarding staff members who are found by OKDHS to have a final administrative finding, per OAC 340:100-3-39, of abuse, neglect, or exploitation.

340:100-6-20. Change of ownership

A license or a contract to operate a group home is not transferable. ~~Whenever ownership~~ Ownership of a group home is transferred can only be changed from the provider named on in the license application to another person or entity which does not have a current license for the group home, the transferee must obtain a probationary provider who has a current group home license or contract, and only upon prior written approval of Oklahoma Department of Human Services (OKDHS).

(1) The transferee shall notify the Department of the transfer and apply for a license or contract for services no less than 30 days prior to the effective date of the transfer.

(2) The transferor shall current group home provider must:

(A) notify the Department Developmental Disabilities Services Division director in writing of the transfer change no less than 30 calendar days prior to the effective date of the transfer change;

(B) and shall remain responsible for the operation of the home until such time as a probationary license or contract is issued to the transferee, change in ownership is complete; and

(C) The transferor shall remain liable for all penalties assessed for violations occurring prior to transfer change of ownership.

(2) Any citations, problems identified by OKDHS prior to the change in ownership, or outstanding deficiencies remaining after the change in ownership are the responsibility of the new owner of the group home to correct.

340:100-6-21. Closing of group home

Any provider of a group home licensed under the rules and regulations in this Subchapter shall or contracted, per OAC 340:100-6, must give 90 calendar days notice prior to closing a home or to closing any part of a home that would require the transfer or discharge of more than 10 ten percent of the residents.

(1) Notice shall must be given to the:

(A) Department Developmental Disabilities Services Division (DDSD) director;

(2) Notice shall be given to:

(AB) any resident who must be transferred requires transfer or discharged discharge from the group home;

(B) the resident's representative; and

(C) the resident's family, where practical legal guardian, family, or advocate.

(3) Notice shall must state the proposed date of closing and the reason for closing.

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- (43) The group home shall provider must offer to assist the resident in securing alternative placement.
- (54) The Department shall DDS director must be notified if there is need for relocation assistance.

PART 5. CONSTRUCTION REQUIREMENTS AND PHYSICAL PLANT REQUIREMENTS

340:100-6-30. General criteria for physical plant

- (a) Plans for construction or remodeling must be submitted to the Oklahoma Department of Human Services and state fire marshal for review and approval prior to the start of construction.
- (b) Mobile homes shall are not be approved.
- (c) Each group home must have been constructed or remodeled to provide an adequate living arrangement for residents.
- (d) Each group home must accommodate the needs of any resident who uses a wheelchair or who has a physical handicap.
- (e) A minimum of 300 square feet of outside yard space shall be provided.
- (f) Each home shall be free of safety hazards.
- (g) The home must be maintained in good repair for operation and appearance.
- (c) Within the corporate limits of a municipality, any new group home must be at least 1200 feet from any other group home and from any similar community residential facility serving persons in drug, alcohol, juvenile, child, parole, and other programs of treatment, care, supervision, or rehabilitation in a community setting, per Section 863 of Title 60 of the Oklahoma Statutes.
- (hd) Residences shall The group home must have interior and exterior features compatible with other residences in the surrounding neighborhood.
- (e) A group home must be located:
- (1) in an area where the local fire department will respond to emergencies; and
 - (2) adjacent to an all-weather road.
- (f) Each group home provider ensures that resident rooms and areas are clean, comfortable, orderly, and provide reasonable privacy.
- (1) Each single resident bedroom must contain a minimum of 80 square feet of floor space.
 - (2) All resident bedrooms must contain a minimum of 60 square feet per person for double or triple occupancy. All new group homes must limit the number of service recipients occupying a bedroom to two.
 - (3) Each resident bedroom must include:
 - (A) a clothes closet or armoire;
 - (B) additional space as needed to accommodate bedside assistance and the use and storage of mobility devices and prosthetic equipment;
 - (C) at least one outside operable window of adequate size installed in a vertical wall that can be used as an emergency exit, unless otherwise approved by the state fire marshal or representative;

- (D) windows that have adjustable coverings to provide privacy;
 - (E) direct access to exits and other areas of the home without passing through another resident's bedroom, a bathroom, or outside; and
 - (F) a full door that can be closed to provide privacy.
- (4) Each resident must have:
- (A) an individual bed of proper size with an adequate mattress, pillow, and bed linens that are clean and in good condition;
 - (B) a bedside table;
 - (C) a bureau, or its equivalent, for storing personal belongings;
 - (D) a chair; and
 - (E) an adequate supply of clean towels and wash cloths, and individual soap.
- (5) Male and female residents are not housed in the same or connected bedrooms, that do not have a full floor-to-ceiling partition and door that can be closed and locked, except a husband and wife may occupy the same bedroom.
- (6) Residents are encouraged to reflect their personal preferences in decorating and furnishing the group home.
- (g) Each group home must provide at least one full-size bathroom for resident use.
- (1) A home for six or more residents must have at least two full-size bathrooms for resident use.
 - (2) Bathrooms must:
 - (A) include a stool, sink, and tub or shower; and
 - (B) provide privacy.
- (h) All licensed group homes must provide common living areas with seating for all residents, excluding the dining room area.
- (i) Tobacco use of any sort is prohibited within the group home. Cigarette butts are properly disposed of in designated areas located outside the home.

340:100-6-31. Plumbing and electrical system **[REVOKED]**

- (a) Electrical, heating, and plumbing facilities must be certified by a licensed plumbing contractor, licensed electrical contractor, or municipal building inspector.
- (b) Ventilation must be provided and the air shall be circulated to assure an environment that will not jeopardize the health or safety of the resident.
- (c) Each home must demonstrate that temperature extremes will not be less than 60° Fahrenheit nor more than 85° Fahrenheit for all areas occupied by residents unless authorized or recommended by a physician.
- (d) Refrigerated air conditioning shall be provided to each resident's room. Refrigerated air conditioning units and vents shall be clean and in good repair.
- (e) A minimum of 20 foot candle power of lighting shall be provided.
- (f) Each resident's bedroom shall have an electrical outlet.

340:100-6-32. Location, general requirements [REVOKED]

- (a) Safe water supply shall be provided in accordance with Board of Health rules.
- (b) Sanitary sewage disposal shall be provided in accordance with Board of Health rules.
- (c) Sanitary garbage disposal is provided.
- (d) Electrical services are provided.
- (e) Property must meet the requirements of local zoning regulations. A letter of approval from zoning authority shall be submitted.
- (f) A group home must be located in an area where the local fire department will respond to emergencies.
- (g) A group home must be located adjacent to an all-weather road.

340:100-6-33. Building elements [REVOKED]

- (a) Adequate enclosed storage space shall be provided for items belonging to residents. Clothing and bedding shall be stored off the floor.
- (b) Laundry equipment, if on premises, shall be housed in a safe, well-ventilated and clean area. Laundry equipment shall be kept clean and dryer shall be vented to outside.
- (c) All doors and windows opening to the outside for ventilation shall be screened. Screens shall be well fitted and in good repair.
- (d) Telephone service must be available and accessible to the resident within the building.
- (e) Linen storage areas shall be provided and be clean and organized.
- (f) Bulk cleaning supplies shall be stored in a separate, clean area.
- (g) Each group home shall have its address clearly visible from the street.
- (h) At least two flashlights for emergency purposes in working order shall be maintained in the group home.

340:100-6-34. Resident rooms and areas [REVOKED]

- (a) Each group home shall ensure that resident rooms and areas are clean, comfortable, orderly, and have reasonably private living accommodations.
- (b) Each single resident room shall contain a minimum of 80 square feet of floor space.
- (c) All resident bedrooms shall contain a minimum of 60 square feet per bed for double or triple occupancy. All new group homes shall limit the number of individuals occupying a bedroom to two.
- (d) Each resident bedroom shall include a clothes closet.
- (e) Each resident room shall provide additional space as needed to accommodate bedside assistance and the use and storage of mobility devices and prosthetic equipment.
- (f) Each resident room shall have at least one outside operable window of adequate size installed in a vertical wall which can be used as an emergency exit. Windows shall have adjustable coverings to provide privacy.

- (g) Each resident shall have an individual bed of proper size, a bedside table and a bureau, or its equivalent, for storing personal belongings. A comfortable chair shall be provided for each resident.
- (h) Each bed shall have an adequate mattress, pillow, and bed linens which are clean and in good condition.
- (i) Each resident shall have an adequate supply of clean towels and wash cloths, and individual soap.
- (j) Male and female residents shall not be housed in the same or adjoining rooms which do not have a full floor to ceiling partition and door which can be closed and locked; except that husband and wife may occupy the same room.
- (k) Each resident's room shall have direct access to exits and other areas of the home without passing through another resident's room, the kitchen, laundry, bathroom, or outside.
- (l) Each resident's room shall have a full door which can be closed to provide privacy.
- (m) Residents shall be encouraged to reflect their personal preferences in the decorating and furnishing of the group home.
- (n) Each group home shall provide a full size bathroom for resident use. A group home for six or more residents shall have two full size bathrooms for resident use. Bathrooms shall include a stool, sink, and tub or shower. They shall be designed for privacy.

340:100-6-35. Lounge area [REVOKED]

- (a) All licensed group homes shall provide common living areas with seating capacity for all the residents. (Dining room area shall not be included.)
- (b) If a home has residents who smoke, an indoor smoking area shall be provided.

PART 7. ENVIRONMENTAL HEALTH, SAFETY, AND SANITARY SANITATION REQUIREMENTS

340:100-6-40. Control of premises [REVOKED]

The manager shall have access to and authority over the entire premises. The person in charge shall be specifically designated in writing by the provider and shall have authority to act in his/her absence and have access to the home's records if the provider or operator is not immediately available.

340:100-6-41. Premises Access to premises

Surroundings shall be kept clean and neat and free from accumulated rubbish, weeds, ponded water or other characteristics of a similar nature which would have a tendency to create a health hazard.

(a) Residents may receive any person in the group home during reasonable hours if the visit does not infringe upon the rights of other residents.

(1) Such person is not permitted to enter the immediate living area of any service recipient without first identifying himself or herself and then receiving permission from the service recipient to enter.

(2) The rights of other service recipients present in the room must be respected.

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- (3) A service recipient may terminate, at any time, a visit by a person having access.
- (b) The group home provider allows:
- (1) visitation and contact with each service recipient's natural family, legal guardian, and friends according to the desires of the service recipient while respecting the rights of other residents; and
- (2) friendships with neighbors, co-workers, and peers according to the desires of the service recipient while respecting the rights of other residents.
- (c) The group home provider may refuse access to the group home to any person when:
- (1) the presence of that person may:
- (A) be injurious to the health and safety of a resident; or
- (B) threaten the security of the property of a resident or the group home; or
- (2) such person seeks access to the group home for commercial purposes.
- (d) OAC 340:100-6-41 does not limit the power of Oklahoma Department of Human Services or any other public agency otherwise permitted or required by law to enter and inspect a group home.

340:100-6-42. Insect and rodent control [REVOKED]

~~Methods shall be employed to prevent the entrance and harborage of insects, spiders, and rodents. Homes shall be kept free of insects, spiders, and rodents.~~

340:100-6-43. Garbage disposal [REVOKED]

- ~~(a) All garbage shall be properly stored and safely disposed of in accordance with local ordinance.~~
- ~~(b) Outdoor garbage waste containers shall have tight fitting covers and shall be insect and rodent resistant.~~
- ~~(c) Approved containers shall be kept clean by washing and airing as needed. Outside storage of garbage in plastic bags is prohibited.~~
- ~~(d) Trash cans in resident areas shall be kept clean.~~

340:100-6-44. Housekeeping and environment

Each group home and its yard must be clean, well-maintained, safe, free from hazards, and adapted to meet the needs of all service recipients.

- (1) Surroundings must be kept clean and neat and free from accumulated rubbish, weeds, ponded water, refuse, discarded furniture, old newspaper, or other items of a similar nature that may create a health hazard.
- (2) The group home provider employs effective methods to prevent the entrance and harborage of insects, spiders, and rodents.
- (3) All garbage must be properly stored and safely disposed of in accordance with local ordinance.
- (A) Trash cans in service recipient areas must be kept clean.
- (B) Outdoor garbage waste containers must be covered and insect and rodent resistant.

(C) Outside storage of garbage in plastic bags is prohibited.

(D) Sanitary garbage disposal must be provided.

(4) Sanitary sewage disposal must be provided in accordance with Oklahoma State Department of Health (OSDH) rules.

~~(a5) The interior and exterior of the group home shall must be safe, clean, and sanitary free of hazards.~~

~~(bA) Practices and procedures shall be utilized to keep the~~ The home must be free from offensive odors, accumulation of dirt, rubbish, dust, and safety hazards.

~~(eB)~~ Floors and floor coverings shall must be clean and in good condition. Floor polishes shall must provide for a non-slip finish.

~~(dC)~~ Walls and ceilings shall must be in good condition and shall be cleaned regularly. All group homes shall must have walls capable of being cleaned.

~~(eD)~~ Deodorizers shall must not be used to cover up odors caused by unsanitary conditions or poor house-keeping practices.

~~(f) Home and surrounding areas shall be kept free from refuse, discarded furniture, and old newspaper.~~

~~(E)~~ Combustibles, such as cleaning rags and compounds, must be kept in closed metal containers in areas away from residents rooms living areas.

~~(F)~~ No items shall can be stored in the hot water heater closet or furnace closet.

~~(gG)~~ General laundry shall must be placed in linen hampers/ or carts with the lids closed.

~~(hH)~~ Linens or clothing soiled with human body fluids shall must be placed in bags or nonporous containers with lids tightly closed.

(6) The group home must have:

(A) a kitchen and equipment to store, prepare, and serve food in a sanitary manner;

(B) utility service and adequate heating, cooling, and plumbing;

(C) lighting that is adequate for the service recipient's activities in each room;

(D) safe water supply in accordance with OSDH rules; and

(E) temperature extremes not less than 65 degrees Fahrenheit nor more than 85 degrees Fahrenheit for all areas occupied by service recipients.

(7) Each service recipient's bedroom must have at least one electrical outlet.

340:100-6-45. Health and safety

(a) The group home provider acts immediately to remedy any situation that poses a risk to the health, well-being, safety, or provision of specified services to any service recipient.

(1) In the event of such a threat, the provider immediately notifies Developmental Disabilities Services Division (DDSD):

(A) of the nature of the situation; and

(B) upon resolution of the threatening situation.

- (2) The provider completes and regularly reviews incident and injury reports per OAC 340:100-3-40.
- (3) In the event of the death of a service recipient, the provider complies with OAC 340:100-3-35.
- (b) An evacuation plan must be developed for each group home. Fire drills must be conducted at least quarterly and severe weather drills must be conducted two times annually.
- (c) The group home must have a written plan for temporary living arrangements in case of fire, climatic conditions that warrant evacuation, or other natural disasters that may render the facility unsuitable.
- (d) Dangerous or deadly weapons are not permitted in the home. Provider agency staff is prohibited from assisting any service recipient to obtain or possess dangerous or deadly weapons. Dangerous or deadly weapons include, but are not limited to:
 - (1) guns or other firearms;
 - (2) crossbows;
 - (3) paint guns;
 - (4) arrows;
 - (5) explosives;
 - (6) stun guns; and
 - (7) knives, except cooking and eating utensils.
- (e) Illegal substances are not permitted in the group home.
- (f) Adequate enclosed storage space in the group home must be provided for items belonging to service recipients.
- (g) Laundry equipment must be:
 - (1) provided in the group home and housed in a safe, well ventilated, and clean area; and
 - (2) kept clean with the clothes dryer vented to the outside.
- (h) All group home doors and windows opening to the outside for ventilation must have screens that are well fitted and in good repair.
- (i) Phone service must be available within the group home and accessible to the service recipient in accordance with his or her Individual Plan.
- (j) Linen storage areas must be clean and organized.
- (k) Any bulk cleaning supplies must be stored in a separate, clean area of the group home.
- (l) The address of each group home must be clearly visible from the street.
- (m) Items required to be in operating condition and accessible for use in the group home are:
 - (1) flashlights;
 - (2) smoke detectors;
 - (3) first aid kit;
 - (4) fire extinguisher; and
 - (5) carbon monoxide detectors.
- (n) Medication administration is performed in accordance with OAC 340:100-5-32.
- (o) Group home staff who assist a resident with bathing or showering must ensure the water temperature is safe and comfortable for the resident being bathed, including when an anti-scald device is used.

PART 9. DIETARY REQUIREMENTS

340:100-6-50. Food service

- (a) A group home ~~shall~~ provider must:
 - (1) have available a minimum of three meals per day, constituting a palatable, nutritionally adequate general diet; and should include the basic four food groups.
 - (2) provide safe and sanitary storage, preparation, and serving of food.
- (b) ~~There shall be no more than 14 hours between the substantial evening meal and the following morning meal. Between meal snacks shall not replace regular meals.~~
- (eb) ~~Fresh drinking water and ice shall~~ must be available and easily accessible to ~~the residents~~ each service recipient.
- (dc) Meal plans are:
 - (1) written in advance for one week;
 - (2) are dated; and are supported by grocery receipts. Substitutions from the planned meals are noted.
 - (3) Meal plans are kept in the home for six months.
 - (i) Grocery receipts are available to document food purchases.
 - (ii) Substitutions from planned meals are noted.
- (ed) ~~Two days' A four-day~~ supply of food shall must be in the home at all times, including cold storage.
- (fe) ~~Dining The dining room seating capacity shall be a minimum of 15 square feet per resident and per~~ must be sufficiently large to simultaneously seat all service recipients and staff on duty, creating family dining atmosphere.
- (gf) ~~A group home having residents provider serving service recipients requiring special diet(s) diets prescribed by a physician shall contract with a consulting registered/licensed dietitian to provide services to institute and monitor these special diets. Special diet menus shall be approved and signed by a registered/licensed dietitian documents effective steps to ensure each service recipient receives the correct diet modifications.~~
- (h) ~~Group homes having residents requiring special diets shall designate an employee who is properly trained to supervise planning, food preparation, food inventory, food distribution, and health issues related to diet.~~
- (i) ~~A group home providing special diets shall ensure that each resident is offered the correct diet.~~
- (j) ~~A group home shall provide safe and sanitary storage, preparation, and serving of food.~~

PART 11. PROGRAM STANDARDS

340:100-6-55. Staffing requirements

- Group homes ~~shall~~ must employ sufficient ~~personnel~~ staff who are appropriately qualified and trained to provide the essential services of the home.
- (1) ~~Sufficient number of persons~~ staff. Each group home ~~shall~~ must have one person who is administratively responsible for the entire program. This person ~~shall~~ must be in addition to ~~the direct care~~ support staff.
 - (A) There ~~shall~~ must be at least one designated person in charge of the home and its operation ~~on duty~~ available for each home ~~whenever residents when~~

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service recipients are present. Staff support and supervision ~~shall must~~ be provided as needed for each resident of service recipient in the home.

~~(B) Each person's interdisciplinary team shall annually assess his or her abilities related to remaining in the home in the absence of on-site staff. All situations in which the resident may remain in the home without staff shall be listed. Programs shall be implemented for each person to reduce his or her dependence on staff supervision, including identifying problems and getting assistance.~~

~~(C) In addition to the direct care support staff, all each service recipient in a group homes home must have a staff person who serves as a program coordinator. The In addition to duties required by OAC 340:100-5-52, program coordinator may be coordination staff must:~~

- ~~(i) a DHS case worker;~~
- ~~(ii) directly employed by the service provider;~~
- ~~or~~
- ~~(iii) employed by another agency with a contractual agreement to provide services to the group home.~~

~~(i) get to know the service recipient and the service recipient's needs;~~

~~(ii) make announced and unannounced visits to the group home that include a minimum of three unannounced monitoring visits per month, based on the needs of the service recipients and the need for supervision of staff. Of the unannounced visits, at least one visit must occur each month:~~

- ~~(I) on Saturday or Sunday; and~~
- ~~(II) between 8:00 p.m. and 7:00 a.m. on a weekday;~~

~~(iii) provide support and assistance to any service recipient who is experiencing an emotional, behavioral, or medical crisis;~~

~~(iv) be accessible to direct support staff 24 hours per day and available to respond, in person if necessary, to an emergency;~~

~~(v) supervise direct support staff to promote achievement of outcomes in the service recipient's Individual Plan (Plan);~~

~~(vi) ensure staffing levels meet the requirements of the service recipient's Plan, with staff trained in accordance with OAC 340:100-3-38;~~

~~(vii) ensure each service recipient's needs are always met, including:~~

- ~~(I) utilities and phone service;~~
- ~~(II) furniture;~~
- ~~(III) food supplies that meet the service recipient's nutritional needs;~~
- ~~(IV) linens;~~
- ~~(V) personal items;~~
- ~~(VI) adaptive equipment; and~~
- ~~(VII) prescription medications;~~

~~(viii) assist the Developmental Disabilities Services Division (DDSD) case manager as requested~~

~~to prepare for and implement the service recipient's Plan and its revisions per OAC 340:100-5-50 through 340:100-5-58;~~

~~(ix) ensure Oklahoma Department of Human Services and Oklahoma Health Care Authority rules are followed; and~~

~~(x) complete necessary training specified in OAC 340:100-3-38.~~

~~(D) All group homes shall home providers must have a signed, written agreement with a registered nurse to:~~

- ~~(i) act as a consultant;~~
- ~~(ii) review medication issues and administration quarterly, or more often if required; and~~
- ~~(iii) provide technical assistance upon request. Documentation of the use of the nurse consultant shall must be maintained by the group home provider.~~

~~(D) Service recipients do not supervise other service recipients.~~

(2) Staff qualifications.

~~(A) The group home has a person designated administratively responsible an administrator and program coordinator who is must:~~

~~(i) be at least 21 years old; and~~

~~(ii) has completed have a minimum of four years of any combination of college level course work applicable to the functions of the group home such as course work in education, special education, social work, sociology, health, psychology or child development, or has at least a high school diploma, and three years of relevant full-time equivalent experience in serving persons with disabilities, unless this requirement is waived in writing by the DDSD director or designee. Both roles may be filled by the same person.~~

~~(B) All other staff have at least a high school education, are must be at least 18 years of age, and have experience relevant to their job description.~~

~~(C) Personnel responsible for providing professional services must be appropriately certified, registered or licensed.~~

~~(C) The provider agency must comply with OAC 340:100-3-39 regarding pre-employment screening for community services workers.~~

~~(3) Staff training. In order to To ensure that all providers achieve and maintain a level of competency necessary to meet the needs of each individual served service recipient in the group home, personnel provider agency staff must complete the following training requirements: specified in OAC 340:100-3-38.~~

~~(A) All employees shall be currently certified in first aid and cardiopulmonary resuscitation (Red Cross training or equivalent). Proof of certification and training shall be kept on file in the home.~~

~~(B) Individuals who administer or monitor medications in a group home shall have successfully completed a training program of medication administration. This shall include training to recognize conditions in residents which may require medical services.~~

~~(C) All training shall be documented and the record kept in the home.~~

~~(D) Group homes shall require staff to complete training as required by the Department.~~

~~(E) Group home staff complete additional training requirements as the residents' specific training needs are identified through the IHP process. (This may exceed the number of required minimum training hours).~~

~~(F) All group home programs shall provide a new employee orientation which includes instruction in the following areas:~~

- ~~(i) policy and procedures regarding abuse and neglect;~~
- ~~(ii) residents' rights;~~
- ~~(iii) confidentiality of personal information and records;~~
- ~~(iv) behavior management rules; and~~
- ~~(v) procedures for handling emergencies.~~

~~(4) Personnel practices.~~

~~(A) Residents shall not supervise other residents.~~

~~(B) The title applied to staff reflects the relationships and patterns of interaction between the staff and individuals served.~~

~~(C) References to individuals are made using terms that are non-stigmatizing, that are age appropriate, and that focus attention on the abilities and accomplishments of individuals as opposed to their disabilities and limitations.~~

~~(D) The behavior of staff reflects sensitivity to the needs of the individuals served for "privacy and dignity". For example, confidentiality and normal sensibility are exercised in speaking about an individual, and undignified displays, exhibitions, or exposure of individuals served, whether deliberate or unintentional, do not occur.~~

~~(E) The agency shall have approved personnel policies and procedures which address such issues as:~~

- ~~(i) job description;~~
- ~~(ii) terms of employment;~~
- ~~(iii) authorized leave procedures;~~
- ~~(iv) grievance procedures; and~~
- ~~(v) professional conduct.~~

340:100-6-56. Provider policies and procedures

(a) Each group home provider must:

- (1) develop and maintain written policies and procedures, as approved by Oklahoma Department of Human Services, that govern all aspects of service provision; and
- (2) make written policies available to each person involved with the service recipient, including parent, legal guardian, advocate, and provider staff.

(b) Group home provider staff must be knowledgeable regarding relevant policies including, but not limited to, service recipient:

- (1) rights;
- (2) services;
- (3) grievance procedures;
- (4) abuse and neglect prevention and reporting;
- (5) confidentiality; and
- (6) emergencies.

(c) Each service recipient has a voice in the development of any policies affecting residents of the group home.

PART 13. INDIVIDUAL HABILITATION PLAN, TRAINING, AND SERVICES

340:100-6-60. Individual habilitation plan (IHP) Plan, service recipient training, and services

(a) Each person receiving services service recipient residing in a group home has a single, comprehensive, written Individual Habilitation Plan (Plan) conforming to OAC 340:100-5-16 340:100-5-50 through 340:100-5-58. Each person's IHP is developed within 30 days of initiation of service by an Interdisciplinary Team including the resident and his/her guardian, family, and/or advocate(s), and is reviewed annually.

(b) The IHP shall address at least the following:

- (1) determination of type of group home staff supervision, i.e., 24 hour when on the premises, 24 hour awake, intermittent;
- (2) determination of type of medication administration, i.e., monitoring, administration, or self administration;
- (3) health care needs and services, including quarterly weight of resident;
- (4) environmental requirements, e.g., communication system, mobility aids, positioning devices, visual aids; and
- (5) Services to be provided or obtained such as:
 - (A) vocational services;
 - (B) physical therapy;
 - (C) speech therapy;
 - (D) transportation; and
 - (E) behavioral support.

(c) Each individual receiving services has an Individual Program Coordinator who is responsible for monitoring and coordinating all activities in the implementation of the IHP. These services are provided in accordance with OAC 340:100-5-15.

(b) Training methods and materials must be culturally normative and age-appropriate.

(c) When specified in the Plan, the group home provider is responsible for programs designed to teach service recipients to clean and maintain their own living areas.

(1) Other household duties may be shared by service recipients on a rotational basis, provided the duties are in keeping with normal routines of daily living and not for the convenience of staff or as work for the group home.

(2) Regular participation in activities, such as meal planning, food purchasing, dish washing, doing laundry, housekeeping, and yard work, that leads to the service

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recipient's greater independence is not considered work for the group home.

(d) Each service recipient's Team annually assesses his or her abilities related to remaining in the home in the absence of on-site staff.

(1) All situations in which the service recipient may remain in the home without staff must be documented in the Plan.

(2) Programs must be implemented for each service recipient to reduce his or her dependence on staff supervision, including identifying problems and getting assistance.

(e) The provider must assist service recipients residing in a group home to access needed professional and generic services.

(f) In addition to requirements in OAC 340:100-5-50 through 340:100-5-58, the Team assesses and addresses the service recipient's needs regarding:

(1) safety in the home;

(2) assistance with money management in addition to requirements in OAC 340:100-3-4;

(3) community inclusion and access to work, employment or day services, leisure, recreation, transportation, and therapies; and

(4) health care per OAC 340:100-5-26.

(g) The group home provider must assist service recipients to access necessary services and supports.

(h) The group home provider establishes a written agreement with the service recipient or legal guardian that defines the financial responsibilities of the provider and service recipient, including a room and board payment.

(1) The agreement:

(A) accurately reflects the ongoing financial arrangement between the provider and service recipient;

(B) clearly defines who purchases personal items;

(C) is renewed annually and when changes occur;

(D) is available to the service recipient, legal guardian, Office of Client Advocacy advocate, and Developmental Disabilities Services Division case manager; and

(E) reflects that the services to be provided are described in the service recipient's Plan.

(2) The room and board payment may include all but \$100 per month of the service recipient's income up to a maximum of 90% of the current Supplemental Security Income rate.

340:100-6-61. Training of the residents [REVOKED]

~~(a) Training programs and services are implemented for each individual in accordance with the individual needs as assessed and prioritized by the individual interdisciplinary team.~~

~~(b) The training shall reflect the principal of normalization. Training methods and materials are culturally normative and age appropriate.~~

~~(c) When appropriate, group homes shall be responsible for training programs designed to teach residents to clean and~~

~~maintain their own living areas. Other household duties may be shared by the residents on a rotational basis, provided the duties are in keeping with normal routines of daily living and not for the convenience of staff or as work for the group home. Regular participation in activities such as meal planning, food purchase, dish washing, laundry, housekeeping, etc. that leads to the resident's greater functional ability (independence) is not considered "work for the group home."~~

340:100-6-62. Services [REVOKED]

~~(a) All residents shall have access to needed professional and/or generic services.~~

~~(b) The professional services accessible to the resident should be the same generic services provided to the general population.~~

~~(c) The services provided or obtained by the group home shall be appropriately documented in the resident's Individual Habilitation Plan.~~

~~(d) The group home shall maintain a cooperative arrangement, preferably in writing, with other agencies or individual practitioners whereby services not ordinarily provided by the group home can be readily obtained.~~

~~(e) The group home shall be responsible for assisting the resident in obtaining necessary services.~~

~~(1) **Vocational services.** The group home shall assist adult residents in acquiring job related skills and/or gainful employment.~~

~~(A) Unless otherwise indicated by the IHP, vocational training or employment shall occur outside the group home for a minimum of five hours per week-day. If vocational services are currently unavailable, an in-house training program developed by the IHP team may be utilized on a temporary basis.~~

~~(B) The group home shall serve in an advocacy role regarding the adequate compensation for labor provided by a resident as defined by the Department of Labor.~~

~~(2) **Health care services.** Health care services are provided in accordance with OAC 340:100-5-26.~~

~~(3) **Transportation.** The group home shall assist individuals in securing transportation that enables them to have access to programs and services.~~

~~(A) The transportation system operated by, or under contract to, the group home shall meet local and state licensing, inspection, insurance, and capacity requirements.~~

~~(B) Vehicles used to transport individuals with physical disabilities shall be adapted to their needs.~~

~~(C) Group home staff drivers shall have valid and appropriate drivers' licenses.~~

~~(D) Group home staff drivers and driver's aides shall be trained in first aid, CPR, and in managing individuals with developmental disabilities.~~

~~(4) **Leisure time.** The group home shall make available, obtain, or facilitate the provision of recreation activities for the enjoyable use of leisure time.~~

~~(A) When recreation and leisure services are available to individuals, the services shall maximize the~~

use of generic programs and resources and include both group and individual activities.

(B) These recreational and leisure services shall accommodate the abilities and interests of each individual and develop new interests and abilities.

(5) ~~Advocacy.~~ The group home shall identify individuals who need or want personal advocates.

(A) The group home shall provide individuals or parents with referral to, and assistance in, obtaining advocacy, guardianship, or protective services.

(B) A group home shall safeguard the rights and welfare of the individual served, including the individual's right to obtain proper professional care, to enjoy privacy and confidentiality in use of information, and be free from undue embarrassment, discomfort, and harassment. The group home shall maintain a Human Rights Committee (HRC) consisting of three or more knowledgeable persons who are not members of the Board of Directors of the provider, employees of the group home, nor related to Board members or employees. The HRC shall meet at least quarterly and maintain minutes of all meetings. Meetings are held to determine that the rights of all clients are fully recognized and protected. At least one third of the Committee's members shall not be employed by or serve as a member of the Board of Directors of a Provider that contracts with DHS/DDSD, and at least one member shall be a primary or secondary recipient of service.

(C) Any agent of a public agency, community legal services program, nonprofit social services, or volunteer group shall be permitted access at reasonable hours to any individual resident of the group home, if the purpose of such organization includes rendering assistance to residents without charge, but only if there is no commercial purpose to the visit. No such person shall enter the immediate living area of any resident without first identifying himself and then receiving permission from the resident to enter. The rights of other residents present in the room shall be respected. A resident may terminate at any time a visit by a person having access under this section.

(f) Behavior management practices conform to OAC 340:100-3-7.

PART 15. MEDICATION STORAGE AND ADMINISTRATION [REVOKED]

340:100-6-70. Medications [REVOKED]

Group homes follow rules regarding medication given in OAC 340:100-5-32.

PART 17. RESIDENTS' FUNDS [REVOKED]

340:100-6-75. Resident's contract [REVOKED]

(a) A written contract shall be executed between a person and his/her representative, if any, and a group home prior to

the time a person is admitted to a group home, or at the expiration of the period of previous contract, or when the source of payment for the resident's care changes from private to public funds, or from public to private funds, or when there are changes in the terms of the contract.

(b) A copy of the contract shall be given to the resident and to the resident's representative, if any, at the time of the resident's admission to the group home.

(c) A copy of the contract for a resident who is supported by non-public funds other than the resident's own funds shall be made available to the person providing the funds for the resident's support.

(d) The contract shall be written in clear and unambiguous language, and shall be printed in type no smaller than standard typewriter pica or elite type. The general form of the contract shall be prescribed by the Department.

- (e) The contract shall specify:
 - (1) the term of the contract;
 - (2) the services to be provided under the contract and the charges for the services;
 - (3) the services that may be provided to supplement the contract and the charges for the services;
 - (4) the sources liable for payments due under the contract;
 - (5) the amount of deposit paid; and
 - (6) the rights, duties, and obligations of the resident, except that the specification of a resident's rights may be furnished on a separate document.

(f) The contract shall designate the name of the resident's representative, if any.

340:100-6-76. Protection of resident's funds [REVOKED]

To protect each resident's funds, the group home follows requirements of OAC 340:100-3-4.

PART 19. INVOLUNTARY TRANSFER OR DISCHARGE OF RESIDENT SERVICE RECIPIENT

340:100-6-85. Transfer or discharge of resident

(a) A group home shall provider must not involuntarily transfer or discharge a resident service recipient residing in a group home except for:

- (1) medical reasons;;
- (2) for the resident's service recipient's safety; or for the safety of other residents;;
- (3) for violations of the contract agreement between the resident service recipient and the group home; provider; or
- (4) for nonpayment for the resident's service recipient's stay unless limited by the Federal-federal Social Security Act.

(b) Involuntary transfer or discharge of a resident service recipient for violations of the contract shall agreement must be subject to:

- (1) review of the contract agreement and notification to the resident service recipient of specific violations;

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- (2) discharge ~~will occur~~ only after all appropriate attempts ~~have been~~ are made to resolve the ~~contract violation(s)~~ any violations. Attempts must be documented in the resident's service recipient's record; and
- (3) review of all proposed discharges by the group home's home Human Rights Committee prior to discharge to determine compliance with due process requirements.
- (c) ~~When a resident leaves a group home service recipient changes provider agencies, only the home shall provide information or a discharge summary if requested, with appropriate written consent from the resident or guardian, by another home, facility, or institution upon their admission of specified resident out-going provider agency claims for services provided on the day the service recipient moves.~~

340:100-6-86. Notice of involuntary transfer or discharge

- (a) Involuntary transfer or discharge of a resident service recipient from a group home ~~shall~~ must be preceded by a minimum written notice of 30 calendar days. ~~Such~~ The notice ~~shall~~ must inform the resident service recipient and resident's representative service recipient's legal guardian or advocate:
- (1) ~~of the right to request a hearing by the Department an administrative inquiry in accordance with OAC 340:100-3-27.1 if they are the service recipient is aggrieved by the decision;~~ and
- (2) ~~how such a hearing request can be~~ is made.
- (b) The 30-day requirement ~~shall~~ does not apply when:
- (1) an emergency transfer or discharge is:
- (A) mandated by the resident's service recipient's health care needs; and
- (B) ~~is~~ in accordance with the written orders and medical justification of the attending physician; and
- (2) the transfer or discharge is necessary due to imminent risk to the lives or health of other residents as documented in the resident's service recipient's record.
- (c) ~~Written notice of involuntary transfer shall be sent to an advocate for the resident if no resident's representative exists.~~

340:100-6-87. Hearing on involuntary transfer or discharge [REVOKED]

- (a) ~~A resident who is aggrieved by an involuntary transfer or discharge may request a hearing by the Department within five work days of receipt of the notice. Requests for hearings should be sent to: Deputy Division Administrator, Developmental Disabilities Services Division, P.O. Box 25352, Oklahoma City, OK 73152.~~
- (b) ~~Hearings and appeals shall be held in accordance with OAC 340:100-3-27, and shall be binding on all parties.~~

340:100-6-88. Transfer by the department OKDHS

- (a) ~~The Department shall~~ Oklahoma Department of Human Services (OKDHS) may initiate the transfer or discharge of a resident service recipient when:

- (1) the ~~resident's service recipient's~~ resident's service recipient's health care needs are not being met according to a licensed medical authority;
- (2) the transfer or discharge is necessary for the physical safety of other residents as observed or as documented in the records, including incident reports, case management records, or other documentation maintained by the group home provider; or
- (3) it is determined, in accordance with applicable OKDHS rules, that a resident's service recipient's rights have been violated or the resident service recipient has been unduly taken advantage of in fiscal matters, or has been physically, mentally, or sexually abused, neglected, or exploited.
- (b) The resident's service recipient's wishes, in all situations, will be given careful consideration in determining whether ~~or~~ not the health and safety aspects involved outweigh the ~~trauma~~ wishes of a resident service recipient being transferred or discharged.

PART 21. RESIDENT'S RESIDENT RIGHTS AND RESPONSIBILITIES

340:100-6-95. Posting Resident rights and distribution responsibilities

~~A copy of residents' rights and responsibilities, procedures for grievance and appeal of grievances, and external complaint procedures shall be conspicuously posted for display in the group home's offices, accessible to residents, employees, and visitors.~~

- (a) Each resident is responsible for making a room and board payment to the group home provider in accordance with the financial agreement.
- (b) Unless otherwise indicated in the resident's Individual Plan, each resident is responsible for participation in meaningful activities, including employment, vocational training, or adult day services that occur outside the group home for a minimum of five hours per weekday.
- (c) Each resident is represented by a Human Rights Committee per OAC 340:100-3-6.
- (d) A statement of rights and responsibilities, developed by each group home, including, but not limited to, each resident's right to:
- (1) civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, that must not be infringed. The provider must encourage and assist in the exercise of these rights;
- (2) private communications and consultations with the resident's physician or attorney or any other person of the resident's choice, including sending and promptly receiving unopened personal mail;
- (3) without fear of reprisal, present grievances, and join with other residents or persons within or outside of the group home to work for improvements in resident care;
- (4) manage his or her financial affairs, unless the resident delegates the responsibility in writing, to the provider. The resident must have at least a quarterly accounting of

any personal financial transactions undertaken on the resident's behalf by the group home provider during any period of time the resident delegates such responsibilities to the provider;

(5) receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Each resident:

(A) must be fully informed by the attending physician of his or her medical condition and proposed treatment in terms and language the resident can understand; and

(B) has the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions;

(6) respect and privacy in the resident's medical care program;

(A) Discussion, consultation, examination, and treatment must remain confidential and be conducted discreetly.

(B) Personal and medical records must be confidential;

(7) retain and use personal clothing and possessions, unless prohibited by law, and security in the storage and use of such clothing and possessions;

(8) be treated courteously and respectfully;

(9) be free from mental and physical abuse, and free from physical and chemical restraints, except physical and chemical restraints authorized in writing by a physician, per Oklahoma Department of Human Services (OKDHS) rules, for a specified period of time;

(10) receive a statement of the group home provider guidelines and an explanation of the resident's responsibility to comply with all reasonable regulations of the group home and to respect the personal rights and private property of the other residents;

(11) receive a statement, if adjudicated incapacitated, stating the rights and responsibilities provided in OAC 340:100-6-95 must be exercised by a court-appointed guardian;

(12) privacy for conjugal visits. A resident may share a room with a spouse, if the spouse resides in the same group home;

(13) all rights specified in OAC 340:100-3-1.2; and

(14) not perform services for a group home provider, except for normal, shared household tasks.

(e) Upon admission of a resident and at least annually thereafter, or upon request, each resident and resident's representative shall advocate or legal guardian must be provided with a copy of this document;

(1) the resident's rights; and

(2) procedures for grievances and appeal, per OAC 340:2-3-54.

(f) The rights enumerated in OAC 340:100-6-95 may be limited for residents of an alternative group home.

340:100-6-96. Statement contents [REVOKED]

~~A statement of rights and responsibilities shall include but not be limited to the rights and responsibilities given in (1)–(13) of this subsection.~~

~~(1) Every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and the group home shall encourage and assist in the exercise of these rights.~~

~~(2) Every resident shall have the right to have private communications and consultations with the physician, attorney or any other person of his/her choice, and may send and promptly receive, unopened, personal mail.~~

~~(3) Every resident shall have the right, without fear of reprisal, to present grievances on behalf of self or others to the group home's staff or administrator, to governmental officials, or to any other person and to join with other residents or individuals within or outside of the facility to work for improvements in resident care.~~

~~(4) Every resident shall have the right to manage his/her own financial affairs, unless the resident or his/her representative, if any, delegates the responsibility, in writing to the group home. The resident and his/her representative, if any, shall have at least a quarterly accounting of any personal financial transactions undertaken in the resident's behalf by the group home during any period of time such responsibilities have been delegated to the group home.~~

~~(5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident shall be fully informed by his/her attending physician of his/her medical condition and proposed treatment in terms and language that the resident can understand, unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions.~~

~~(6) Every resident shall receive respect and privacy in his/her medical care program. Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential.~~

~~(7) Every resident shall have the right to retain and use his/her personal clothing and possessions, unless medically contraindicated, and shall have the right to security in the storage and use of such clothing and possessions.~~

~~(8) Every resident shall have the right to receive courteous and respectful care and treatment and a written statement of the services provided by the group home, including those required to be offered on an as-needed basis, and a statement of related charges, including any costs for services not covered under medicare or medicaid, or not covered by the group home's basis per diem rate.~~

~~(9) Every resident shall be free from mental and physical abuse, and from physical and chemical restraints as provided by DHS policy.~~

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(10) Every resident shall receive a statement of the facility's regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of the other residents.

(11) No resident shall be required to perform services for a group home. Regular participation in shared household tasks shall not be construed to mean "services for a group home" when said tasks are included as part of a training, habilitation, or rehabilitation plan for the resident and are performed as a part of normal shared household tasks.

(12) Every resident shall have privacy for spousal visits. Every resident may share a room with their spouse, if the spouse is residing in the same group home.

(13) When a physician indicates it is appropriate, a group home shall immediately notify the resident's next of kin, or representative of the resident's death or when the resident's death appears to be imminent.

340:100-6-97. Denial of care

No licensed facility shall ~~A group home provider cannot~~ deny appropriate care on the basis of the resident's source of payment as defined in the regulations.

340:100-6-98. Written plan and training [REVOKED]

Each group home shall prepare a written plan and provide appropriate staff training to implement each resident's rights as stated.

SUBCHAPTER 17. EMPLOYMENT SERVICES

PART 5. OTHER STATE FUNDED VOCATIONAL EMPLOYMENT SERVICES

340:100-17-30. Other State state funded vocational employment services

State funded employment services may supplement ~~vocational employment~~ services offered through the ~~Home and Community-Based Community Waiver and Homeward Bound Waiver, which are explained in per OAC 317:40-7.~~

(1) State funded vocational employment services with procedure codes include:

(A) ~~Therapeutic Leave~~ therapeutic leave, limited to 150 ~~units~~ hours per ~~consumer-service recipient~~ each ~~12 months, (W4738)~~ fiscal year.

(i) Each ~~consumer of Waiver Vocational Services~~ service recipient is eligible for up to 150 hours of therapeutic leave absence per fiscal year if the service recipient receives:

- (I) center-based prevocational services;
- (II) community-based prevocational services;
- (III) enhanced community-based prevocational services;

(IV) individual placement in community-based services; or

(V) supplemental supports.

(ii) ~~Consumer absences from vocational programming, to be considered therapeutic Therapeutic leave, may be due to used for:~~

(I) legal holidays, maximum of 12 days per fiscal year;

(II) consumer service recipient or family initiated vacations;

(III) consumer service recipient medical appointment, concerns concern, illness, or injury;

(IV) severe weather conditions; or

(V) ~~consumer's doctor or medical appointment.~~

(~~VI~~) consumer service recipient refusal to attend the employment program.

(iii) When a consumer service recipient is absent for more than five consecutive days due to illness, the ~~consumer's service recipient's~~ Team meets to discuss possible:

(I) ~~possible~~ needed program interventions; and

(II) ~~possible~~ suspension of the ~~consumer's vocational service recipient's employment~~ program to avoid exhausting all available therapeutic leave.

(iv) When a consumer service recipient refuses to attend his or her ~~vocational employment~~ program for three consecutive days, the Team, including residential staff, meets to discuss possible program changes. ~~Further claims are not paid The employment provider cannot claim for therapeutic leave beyond the three consecutive days until the Team meets has met.~~

(v) ~~Supporting Claims for therapeutic leave require supporting documentation for consumer absences claims that includes the Vocational Services Time Sheet, Form DDS 42, denoting the date, and length of absence, and specific reason for absence.~~

(vi) The provider can claim for therapeutic leave only for the number of scheduled work hours the consumer service recipient missed.

(vii) ~~Claims for consumer absences The provider cannot be made if claim for therapeutic leave when the:~~

(I) provider agency is closed or for reasons other than severe weather conditions;

(II) if the provider staff is absent, other than on legal holidays; or

(~~viii~~III) ~~Claims for consumer absence are not paid if the service recipient's absence is caused by the provider's inability to supply trained back-up staff;~~

(viii) The provider pays the direct support staff member the salary that the staff member would have earned if the:

(I) provider bills for therapeutic leave; and

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[OAR Docket #07-687]

- (II) direct support staff member is unable to work due to the absence of the service recipient.
 - ~~(B) Center Based — Prevocational — Services (W4774);~~
 - ~~(C) Community Based — Prevocational — Services (W4775);~~
 - ~~(D) Enhanced — Community Based — Services (W4776);~~
 - (B) center-based prevocational services;
 - (C) individual placement in community-based services;
 - (D) community-based prevocational services;
 - (E) enhanced community-based services;
 - (F) individual placement in job coaching services;
 - ~~(EG) Job Coaching job coaching services (W4032);~~
 - ~~(FH) Enhanced Job Coaching enhanced job coaching services (W4778); and~~
 - ~~(GI) Stabilization stabilization and extended services (W4034);; and~~
 - (J) employment training specialist services.
- (2) ~~State funded vocational employment services listed in paragraph (1) of this subsection are available to:~~
- ~~(A) to class members of the Homeward Bound vs. The Hissom Memorial Center (THMC) class who are not eligible for Home and Community Based Waiver DDSD waiver services; and~~
 - ~~(B) to consumers service recipients who are transitioning from a Title XIX ICF or ICF/MR; public or private intermediate care facility for the mentally retarded (ICF/MR), an intermediate care facility, or a skilled nursing facility.~~
- (i) ~~If assessment activities occur prior to community placement, while the consumer is still residing in an ICF, public or private ICF MR, or a Skilled Nursing Facility, then state funds for up to 40 documented units hours of Employment Training Services employment training services may be claimed for assessment, staff training, and or meetings.~~
 - ~~(ii) For members of the THMC vs. Homeward Bound class residing in Title XIX ICFs and ICFs/MR, a portion of the 150 hours for Stabilization and Extended Services can be billed for pre-exit services with approval of the consumer's case manager;~~
 - ~~(C) in pre approved situations when the absence of the consumer prevents service reimbursement through the Medicaid waiver; and~~
 - ~~(D) in other pre approved situations in which Home and Community Based Waiver funds are not available.~~

[OAR Docket #07-567; filed 3-28-07]

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PERMANENT final adoption

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None

INCORPORATIONS BY REFERENCE:

None

ANALYSIS:

The rule change adds a definition for seasonal retailer in order to keep the definitions in all Title 429 chapters consistent (rules relating to a seasonal retailer are in Chapter 10 of Title 429). This will allow a seasonal retailer to remain a lottery retailer even though sales may not meet minimum sales requirements in the off-seasons.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 12, 2007:

429:1-1-3. Definitions

In addition to terms defined in the Oklahoma Education Lottery Act, the following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

"Act" means the Oklahoma Education Lottery Act.

"Active Game" means a lottery game currently available for sale from the Oklahoma Lottery Commission.

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"Activated Pack" means the status of a pack of tickets which indicates to the OLC that tickets are being sold from that pack.

"Altered Ticket" means any ticket intentionally changed by a player or by other persons or means in an attempt to make the ticket appear as a winning ticket.

"Authorized Location" means a business authorized by a contract with OLC to sell OLC Lottery products. **"Authorized Location"** and **"Authorized Retailer"** are synonymous terms.

"Automatic Win Symbol" means any symbol that, when revealed under the removable covering on an instant ticket, automatically wins a prize for the player.

"Breaks" means a gap of one or more numbered instant tickets in a pack number sequence.

"Cancelled Ticket" means any OLC ticket for which the ticket sale and/or validation information has been deleted from OLC records.

"Caption" means the letters appearing near the play symbols in the instant ticket play area that verify the correctness of play symbols.

"Certified Drawing" means a drawing in which the lottery and an independent accountant attests that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.

"Claim Center" means an OLC authorized location available to pay claims for prizes of more than \$600. A "Claim Center" may also be a retailer authorized by the Board to pay prizes up to five thousand dollars (\$5,000.00) without regard to where the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.

"Claim Form" means the printed form authorized by OLC that a player shall complete and submit to OLC along with a ticket to determine eligibility for prize payment, in the event that such prize has not been validated and paid by an OLC retailer.

"Claimant" means a player who has submitted a claim for prize payment.

"Claim Period" means the period of time prescribed by the Act during which players must claim cash prizes. For instant games, the claim period is ninety (90) days after the announced end of the game. For online games, the claim period is one hundred eighty (180) days after the drawing date.

"Computer Selected Items" means numbers or groups of numbers selected for a player by the computer in online games. Also known as auto picks, quick picks, or computer picks.

"Counterfeit Ticket" means any ticket not produced by an OLC authorized ticket printer or an OLC online games sales terminal.

"Defectively Printed Tickets" means the same as misregistered ticket.

"Display Printing" means the printing on the ticket not associated with the ticket game play.

"District Office" means an OLC claim center, if any, in various cities in Oklahoma.

"Disputed Ticket" means a ticket which the claimant believes is a prize winning ticket, but which fails OLC validation procedures.

"Doubler" means any method used on a ticket to double a prize amount.

"Draw Procedures" means the written document approved by OLC that specifies the process for selecting winners for a particular instant game or instant game promotion, if a drawing is designed as part of the game or promotion, and for each online game or online game promotion.

"Drawing" means the process by which the lottery randomly selects numbers or items in accordance with the specific game rules or game promotion rules for those games or game promotions requiring random selection of numbers or items.

"Duplicate Ticket" means a ticket produced by photograph, xerography or any other duplication method other than an authorized instant ticket printed for OLC or generated by an authorized online terminal.

"Electronic Funds Transfer" or **"EFT"** means the process by which the OLC transfers funds from a retailer authorized bank account to pay amounts due the OLC or by which OLC provides funds to a retailer for payment of prizes.

"Entry" means a lottery ticket or other OLC authorized document submitted to OLC or any OLC authorized party for participation in an OLC drawing.

"Executive Director" means the chief executive officer and administrator of the Oklahoma Lottery Commission.

"Finalist" means a person selected through a preliminary drawing for participation in a grand prize drawing.

"Floating Image Play Area" means the play area of each instant ticket which may print in a slightly different position on game tickets as a security measure.

"Game Board" means a pre-printed OLC form for use by players in selecting numbers for online games (see "Play Slip").

"Game Name" means the name of the Instant or Online game, as specified in the game procedures.

"Game Number" means the preprinted number on an instant ticket which identifies a particular game.

"Game Report" means a report prepared after a game end showing, at a minimum, the number of tickets sold and the number of prizes awarded in the game.

"Game Specifications Document" means the same as working papers.

"Grand Prize Drawing" means an event in which qualified players/contestants are awarded prizes in a random manner and as provided in OLC approved procedures.

"High-Tier Prize" means a prize of \$601 or more.

"Instant Game" means an instant ticket lottery game offered by OLC for sale to the public that is played by revealing a hidden play area on a ticket to display the play symbols.

"Instant Game Procedures" means the document summarizing the game specifications as provided in the working papers for each Instant Game.

"Instant Game Promotion Procedures" means the OLC approved procedures for player participation in any Instant Game Promotion.

"Jackpot" means a large prize; often the top prize in an online game.

"Lottery Retailer" or **"Retailer"** means a business entity contracted to OLC to sell lottery tickets.

"Low-Tier Prize" means a prize of twenty-five dollars (\$25) or less.

"Mid-Tier Prize" means a prize of \$25.01-\$600.

"Minor" means an individual younger than 18 years of age.

"Miscut Ticket" means a ticket cut during production such that the ticket is not whole and able to be validated.

"Misregistered Ticket" means any ticket on which printed data has been misprinted in such a manner as to prevent reading during the validation process.

"Mutilated Ticket" means any lottery ticket accidentally or intentionally damaged such that completion of OLC validation procedures is not possible.

"Non-Cash Prize" means merchandise prizes offered in lottery games or lottery promotions.

"Oklahoma Lottery Retailer Contract" means Parts 1 through 8 of the Lottery Retailer Sales Contract Application, Title 3A, Section 701 ff of the Oklahoma Statutes as amended, Emergency and Permanent Rules approved by the OLC Board. As used in these Rules the terms, **"Retailer Contract," "Oklahoma Ticket Sales Contract," "Lottery Retail Sales Contract,"** and **"Lottery Retailer Sales Contract"** all mean **"Oklahoma Lottery Retailer Contract"**.

"OLC" means the Oklahoma Lottery Commission.

"Online Game" means a game where tickets or shares are purchased through a network of sales terminals located at OLC authorized retail outlets through use of an OLC authorized play slip or manual retailer input of player requested numbers. "Online Game" does not include a game played via the Internet.

"Online Game Procedures" means the document summarizing game specifications for each online game offered for sale by OLC.

"Online Game Promotion Procedures" means the document summarizing promotion specifications for each online game promotion offered by OLC.

"Online Terminal" means the OLC authorized sales terminal used to sell various online lottery number games.

"Pack" or **"Pack Size"** means a package of instant tickets, each ticket with a different number. The number of tickets in a pack is generally from 60 to 500.

"Pack Number" means the unique number on the ticket that designates each pack of instant tickets in the game. Each pack number is unique within each instant game.

"Play Area" means the covered area of an instant ticket that contains the ticket play symbols.

"Play Central ? Lottery Kiosk" means a self-service ticket vending machine that allows the player to purchase instant tickets and/or online game tickets without any clerk assistance.

"Play Panel" means an area on an online game play slip or game board used by a player to select numbers for a single online game play.

"Play Slip" means a pre-printed OLC form for use by players in selecting numbers for online games (see game board).

"Play Spot" means an authorized area on an instant ticket containing one play symbol and one caption.

"Play Station" means a stand-alone unit provided by OLC for the display of lottery game brochures play slips, etc.

"Play Style" means the method of play to determine a winner for an individual game or game promotion.

"Play Symbol" means the printed data under the removable covering on the front of an instant ticket that is used to determine eligibility for a prize. The symbols for individual games will be specified in individual instant game procedures.

"Player-Selected Item" means a number or item or group of numbers or items selected by a player in connection with an online game.

"Point of Sale Material" or **"POS"** means flyers, brochures, posters and signage used within/at lottery retail locations to identify the products and games available for sale, as well as to provide general information (i.e. odds, jackpot amounts, prize levels and beneficiaries).

"Point of Purchase Material" or **"POP"** is synonymous with POS.

"Preliminary Drawing" means an event for the selection of contestants for a grand prize drawing.

"Price Point" means the retail selling price of an individual game ticket.

"Printer Omitted Tickets" means any tickets designated by OLC's instant ticket printer as having been omitted from the ticket order quantity for reasons stated by the ticket printer.

"Prize" means a cash amount or product (merchandise) that can be won in a lottery game or game promotion.

"Prize Drawing" means a method for determining game or game promotion winners, as defined in OLC procedures.

"Prize Structure" means the number, value, and odds of winning prizes for an individual game as approved by OLC in individual game procedures.

"Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract.

"Retailer Commission" means the amount of money paid to retailers for selling lottery products.

"Retailer Paid Prizes" means prizes which may be paid by retailers subject to OLC validation procedures.

"Retail Sales Price" means the OLC designated price OLC retailers must charge for a ticket when sold.

"Retailer Ticket Order Quantity" means the number of tickets or packs of tickets ordered by the retailer from OLC or its authorized distributor.

"Retailer Validation Code" means the code found under the covered area over the play symbols on the front of the instant ticket which the OLC retailer may use to verify and validate low-tier winners.

"Seasonal Retailer" means a business which sells Lottery tickets or shares on behalf of OLC pursuant to a retailer contract and whose business may be closed for some portion of the year and/or whose business hours may be significantly reduced for some portion of the year due to the seasonal nature

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of the business. Businesses that are closed temporarily for re-modeling, change of ownership, or similar temporary closings will not be deemed to be seasonal retailers.

"**Settled Pack**" means the status of an activated pack of instant tickets when the OLC has invoiced the retailer based upon a pre-determined formula or schedule and the retailer has paid for the pack.

"**Share**" means any intangible evidence of participation in a lottery game.

"**Ticket**" means any tangible evidence issued by the lottery to provide participation in a lottery game or drawing authorized by the Act.

"**Ticket Number**" means the number on the ticket that refers to the ticket sequence within the pack.

"**Ticket Order Quantity**" means the number of tickets or packs of tickets ordered by OLC from the instant ticket printer.

"**Unreadable Ticket**" means any ticket on which any play data or other ticket validation information cannot be read as part of the prize validation procedure.

"**Validation Number**" means the unique data printed on a ticket that enables verification of the ticket as a valid winner.

"**Validation Procedures**" means the procedures utilized by OLC and/or its authorized vendors to determine if a claimed ticket is a valid winner.

"**Valid Ticket**" means a ticket which meets all OLC game specifications and OLC validation requirements.

"**Variant**" means a symbol used in conjunction with certain play styles and may include a symbol that serves as a "wild card" to complete a winning combination of play symbols.

"**VIRN (Void If Removed Numbers)**" means a series of numbers under the removable covering on an instant ticket to be used in the validation process.

"**Wild**" means a symbol or word, different from all the others in an instant game, used to complete a match on a winning ticket.

"**Working Papers**" means the written document approved by the OLC for instant game production that includes, among other things, the game name, the art work for the front and back of the ticket, how a prize is won, game prize structure, play style, ticket delivery schedule to OLC, and eligibility for a drawing, if any.

[OAR Docket #07-687; filed 4-5-07]

TITLE 429. OKLAHOMA LOTTERY COMMISSION CHAPTER 10. RETAILER PROVISIONS

[OAR Docket #07-688]

RULEMAKING ACTION:
PERMANENT final adoption

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429:10-1-2 [AMENDED]
429:10-1-3 [AMENDED]
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429:10-1-8 [AMENDED]
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January 22, 2007

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Failure of the Legislature to disapprove the rules resulted in approval on March 27, 2007

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May 12, 2007

SUPERSEDED EMERGENCY ACTIONS:

None

INCORPORATIONS BY REFERENCE:

None

ANALYSIS:

The proposed rule amendments add a definition for seasonal retailer and allow the Lottery to waive minimum sales requirements for seasonal retailers. This will allow a seasonal retailer to remain a lottery retailer even though sales may not meet minimum sales requirements in the off-seasons. The rules allow compensation to certain retailers for assisting in the filing of claims that cannot be paid at the retailer location and that are forwarded to the Lottery Commission for payment. The rules modify retailer selection criteria relating to pawnbrokers, supervised lenders, deferred deposit lenders, payday lenders, or applicants whose primary business is categorized as a check casher to match the language in SB 1089 passed by the 2006 legislature, ensuring consistency with existing law. The rules modify procedures to require retailers to use the online game sales confirmation screen whenever the total ticket cost exceeds \$25 ensuring accuracy of payment. The rules clarify instructions related to payment of prizes; make retailer invoices available earlier in the day and correct the accounting period for purposes of preparing retailer invoices. The rules allow for earlier settlement of packs when a retailer activates multiple packs of tickets from the same game making payment for the packs more timely.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 12, 2007:

429:10-1-2. Definitions

In addition to terms defined in the Oklahoma Education Lottery Act, the following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

"**Act**" means the Oklahoma Education Lottery Act.

"**Active Game**" means a lottery game currently available for sale from the Oklahoma Lottery Commission.

"Activated Pack" means the status of a pack of tickets which indicates to the OLC that tickets are being sold from that pack.

"Altered Ticket" means any ticket intentionally changed by a player or by other persons or means in an attempt to make the ticket appear as a winning ticket.

"Authorized Location" means a business authorized by a contract with OLC to sell OLC Lottery products. **"Authorized Location"** and **"Authorized Retailer"** are synonymous terms.

"Automatic Win Symbol" means any symbol that, when revealed under the removable covering on an instant ticket, automatically wins a prize for the player.

"Breaks" means a gap of one or more numbered instant tickets in a pack number sequence.

"Cancelled Ticket" means any OLC ticket for which the ticket sale and/or validation information has been deleted from OLC records.

"Caption" means the letters appearing near the play symbols in the instant ticket play area that verify the correctness of play symbols.

"Certified Drawing" means a drawing in which the lottery and an independent accountant attests that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.

"Claim Center" means an OLC authorized location available to pay claims for prizes of more than \$600. A "Claim Center" may also be a retailer authorized by the Board to pay prizes up to five thousand dollars (\$5,000.00) without regard to where the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.

"Claim Form" means the printed form authorized by OLC that a player shall complete and submit to OLC along with a ticket to determine eligibility for prize payment, in the event that such prize has not been validated and paid by an OLC retailer.

"Claimant" means a player who has submitted a claim for prize payment.

"Claim Period" means the period of time prescribed by the Act during which players must claim cash prizes. For instant games, the claim period is ninety (90) days after the announced end of the game. For online games, the claim period is one hundred eighty (180) days after the drawing date.

"Computer Selected Items" means numbers or groups of numbers selected for a player by the computer in online games. Also known as auto picks, quick picks, or computer picks.

"Counterfeit Ticket" means any ticket not produced by an OLC authorized ticket printer or an OLC online games sales terminal.

"Defectively Printed Tickets" means the same as misregistered ticket.

"Display Printing" means the printing on the ticket not associated with the ticket game play.

"District Office" means an OLC claim center, if any, in various cities in Oklahoma.

"Disputed Ticket" means a ticket which the claimant believes is a prize winning ticket, but which fails OLC validation procedures.

"Doublor" means any method used on a ticket to double a prize amount.

"Draw Procedures" means the written document approved by OLC that specifies the process for selecting winners for a particular instant game or instant game promotion, if a drawing is designed as part of the game or promotion, and for each online game or online game promotion.

"Drawing" means the process by which the lottery randomly selects numbers or items in accordance with the specific game rules or game promotion rules for those games or game promotions requiring random selection of numbers or items.

"Duplicate Ticket" means a ticket produced by photograph, xerography or any other duplication method other than an authorized instant ticket printed for OLC or generated by an authorized online terminal.

"Electronic Funds Transfer" or **"EFT"** means the process by which the OLC transfers funds from a retailer authorized bank account to pay amounts due the OLC or by which OLC provides funds to a retailer for payment of prizes.

"Entry" means a lottery ticket or other OLC authorized document submitted to OLC or any OLC authorized party for participation in an OLC drawing.

"Executive Director" means the chief executive officer and administrator of the Oklahoma Lottery Commission.

"Finalist" means a person selected through a preliminary drawing for participation in a grand prize drawing.

"Floating Image Play Area" means the play area of each instant ticket which may print in a slightly different position on game tickets as a security measure.

"Game Board" means a pre-printed OLC form for use by players in selecting numbers for online games (see "Play Slip").

"Game Name" means the name of the Instant or Online game, as specified in the game procedures.

"Game Number" means the preprinted number on an instant ticket which identifies a particular game.

"Game Report" means a report prepared after a game end showing, at a minimum, the number of tickets sold and the number of prizes awarded in the game.

"Game Specifications Document" means the same as working papers.

"Grand Prize Drawing" means an event in which qualified players/contestants are awarded prizes in a random manner and as provided in OLC approved procedures.

"High-Tier Prize" means a prize of \$601 or more.

"Instant Game" means an instant ticket lottery game offered by OLC for sale to the public that is played by revealing a hidden play area on a ticket to display the play symbols.

"Instant Game Procedures" means the document summarizing the game specifications as provided in the working papers for each Instant Game.

"Instant Game Promotion Procedures" means the OLC approved procedures for player participation in any Instant Game Promotion.

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"Jackpot" means a large prize; often the top prize in an online game.

"Lottery Retailer" or **"Retailer"** means a business entity contracted to OLC to sell lottery tickets.

"Low-Tier Prize" means a prize of twenty-five dollars (\$25) or less.

"Mid-Tier Prize" means a prize of \$25.01-\$600.

"Minor" means an individual younger than 18 years of age.

"Miscut Ticket" means a ticket cut during production such that the ticket is not whole and able to be validated.

"Misregistered Ticket" means any ticket on which printed data has been misprinted in such a manner as to prevent reading during the validation process.

"Mutilated Ticket" means any lottery ticket accidentally or intentionally damaged such that completion of OLC validation procedures is not possible.

"Non-Cash Prize" means merchandise prizes offered in lottery games or lottery promotions.

"Oklahoma Lottery Retailer Contract" means Parts 1 through 8 of the Lottery Retailer Sales Contract Application, Title 3A, Section 701 ff of the Oklahoma Statutes as amended, Emergency and Permanent Rules approved by the OLC Board. As used in these Rules the terms, **"Retailer Contract," "Oklahoma Ticket Sales Contract," "Lottery Retail Sales Contract,"** and **"Lottery Retailer Sales Contract"** all mean **"Oklahoma Lottery Retailer Contract"**.

"OLC" means the Oklahoma Lottery Commission.

"Online Game" means a game where tickets or shares are purchased through a network of sales terminals located at OLC authorized retail outlets through use of an OLC authorized play slip or manual retailer input of player requested numbers. "Online Game" does not include a game played via the Internet.

"Online Game Procedures" means the document summarizing game specifications for each online game offered for sale by OLC.

"Online Game Promotion Procedures" means the document summarizing promotion specifications for each online game promotion offered by OLC.

"Online Terminal" means the OLC authorized sales terminal used to sell various online lottery number games.

"Pack" or **"Pack Size"** means a package of instant tickets, each ticket with a different number. The number of tickets in a pack is generally from 60 to 500.

"Pack Number" means the unique number on the ticket that designates each pack of instant tickets in the game. Each pack number is unique within each instant game.

"Play Area" means the covered area of an instant ticket that contains the ticket play symbols.

"Play Central[®] Lottery Kiosk" means a self-service ticket vending machine that allows the player to purchase instant tickets and/or online game tickets without any clerk assistance.

"Play Panel" means an area on an online game play slip or game board used by a player to select numbers for a single online game play.

"Play Slip" means a pre-printed OLC form for use by players in selecting numbers for online games (see game board).

"Play Spot" means an authorized area on an instant ticket containing one play symbol and one caption.

"Play Station" means a stand-alone unit provided by OLC for the display of lottery game brochures play slips, etc.

"Play Style" means the method of play to determine a winner for an individual game or game promotion.

"Play Symbol" means the printed data under the removable covering on the front of an instant ticket that is used to determine eligibility for a prize. The symbols for individual games will be specified in individual instant game procedures.

"Player-Selected Item" means a number or item or group of numbers or items selected by a player in connection with an online game.

"Point of Sale Material" or **"POS"** means flyers, brochures, posters and signage used within/at lottery retail locations to identify the products and games available for sale, as well as to provide general information (i.e. odds, jackpot amounts, prize levels and beneficiaries). **"Point of Purchase Material"** or **"POP"** is synonymous with POS.

"Preliminary Drawing" means an event for the selection of contestants for a grand prize drawing.

"Price Point" means the retail selling price of an individual game ticket.

"Printer Omitted Tickets" means any tickets designated by OLC's instant ticket printer as having been omitted from the ticket order quantity for reasons stated by the ticket printer.

"Prize" means a cash amount or product (merchandise) that can be won in a lottery game or game promotion.

"Prize Drawing" means a method for determining game or game promotion winners, as defined in OLC procedures.

"Prize Structure" means the number, value, and odds of winning prizes for an individual game as approved by OLC in individual game procedures.

"Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract.

"Retailer Commission" means the amount of money paid to retailers for selling lottery products.

"Retailer Paid Prizes" means prizes which may be paid by retailers subject to OLC validation procedures.

"Retail Sales Price" means the OLC designated price OLC retailers must charge for a ticket when sold.

"Retailer Ticket Order Quantity" means the number of tickets or packs of tickets ordered by the retailer from OLC or its authorized distributor.

"Retailer Validation Code" means the code found under the covered area over the play symbols on the front of the instant ticket which the OLC retailer may use to verify and validate low-tier winners.

"Seasonal Retailer" means a business which sells Lottery tickets or shares on behalf of OLC pursuant to a retailer contract and whose business may be closed for some portion of the year and/or whose business hours may be significantly reduced for some portion of the year due to the seasonal nature

of the business. Businesses that are closed temporarily for remodeling, change of ownership, or similar temporary closings will not be deemed to be seasonal retailers.

"**Settled Pack**" means the status of an activated pack of instant tickets when the OLC has invoiced the retailer based upon a pre-determined formula or schedule and the retailer has paid for the pack.

"**Share**" means any intangible evidence of participation in a lottery game.

"**Ticket**" means any tangible evidence issued by the lottery to provide participation in a lottery game or drawing authorized by the Act.

"**Ticket Number**" means the number on the ticket that refers to the ticket sequence within the pack.

"**Ticket Order Quantity**" means the number of tickets or packs of tickets ordered by OLC from the instant ticket printer.

"**Unreadable Ticket**" means any ticket on which any play data or other ticket validation information cannot be read as part of the prize validation procedure.

"**Validation Number**" means the unique data printed on a ticket that enables verification of the ticket as a valid winner.

"**Validation Procedures**" means the procedures utilized by OLC and/or its authorized vendors to determine if a claimed ticket is a valid winner.

"**Valid Ticket**" means a ticket which meets all OLC game specifications and OLC validation requirements.

"**Variant**" means a symbol used in conjunction with certain play styles and may include a symbol that serves as a "wild card" to complete a winning combination of play symbols.

"**VIRN (Void If Removed Numbers)**" means a series of numbers under the removable covering on an instant ticket to be used in the validation process.

"**Wild**" means a symbol or word, different from all the others in an instant game, used to complete a match on a winning ticket.

"**Working Papers**" means the written document approved by the OLC for instant game production that includes, among other things, the game name, the art work for the front and back of the ticket, how a prize is won, game prize structure, play style, ticket delivery schedule to OLC, and eligibility for a drawing, if any.

429:10-1-3. Retailer compensation

(a) Retailers will earn six-percent (6%) for each dollar of ticket sales plus three-quarters of one-percent (.75%) for each dollar of prizes \$600.00 or less paid by the retailer.

(b) In the event OLC designates certain retailers to pay prizes of up to \$5,000, pursuant to the Act and 429:10-1-7(b) (relating to payment of prizes), retailers so designated shall earn six-percent (6%) for each dollar of ticket sales plus three-quarters of one-percent (.75%) for each dollar of prizes \$5,000 or less paid by the retailer; retailers so designated will receive \$10 for each prize claim processed and forwarded to OLC for payment.

429:10-1-4. Retailer selection criteria

In addition to the retailer selection criteria in the Act, OLC will consider the criteria enumerated herein:

(1) It is the intent of OLC that all retailers sell both instant and online (computerized or pick-you-own numbers) games, thus retailer selection criteria for retailers of instant tickets and retailers of online (computerized or pick-your-own numbers) games are identical.

(2) Retailer applicants shall, at the time of application, consent to the requirements of the Act and the requirements enumerated herein, which may be revised and/or amended by the OLC subject to Board approval and notification to retailers.

(3) Persons applying to become lottery retailers shall be charged a uniform application fee of \$95. The OLC may designate a portion of this fee as a non-refundable application fee and the remaining portion to cover the retailer bonding requirements;

(4) All lottery retailer contracts may be renewable annually from the date of issuance at the discretion of the OLC, unless sooner canceled or terminated.

(5) ~~It is the intent of OLC that contracting with supervised lenders [See 14A O.S., §3-501 (relating to supervised vendors)], pawnshops, payday lenders, deferred deposit lenders and businesses whose primary business is categorized as a check casher for the sale of OLC products is not in the best interest of OLC and the State, thus applications from such businesses to become an OLC retailer will not be accepted or approved by OLC. No certificate of authority to act as a lottery retailer shall be issued to any applicant doing business or who holds a license to do business as a pawnbroker, supervised lender, or deferred deposit lender, also known as a payday lender, or whose primary business is categorized as a check casher.~~

429:10-1-6. Acceptance of online tickets

(a) Retailers shall agree that all online tickets cannot be cancelled once printed.

(b) Retailers shall utilize the online game sales confirmation screen or prompt to advise players of the cost of the player's ticket selection cost whenever the total cost exceeds \$20.00 \$25.00, or whenever multiple draw tickets are requested or multiple tickets are requested for a single draw; for each individual transaction, this player confirmation will occur prior to actual printing and sale of the tickets.

429:10-1-7. Payment of prizes

(a) During the retailer's normal business hours, retailers are required to pay prizes \$600.00 or under. Retailers are encouraged to pay in cash, but they may pay mid-tier prizes (\$25.01 to \$600) with a business check or money order if this is disclosed in advance to the claimant. Consistent reported failure to pay prizes to claimants or the issuance of a non-sufficient funds (NSF) check to claimants may be sufficient grounds to suspend or terminate the retailer contract.

(b) OLC may authorize designated retailers to pay prizes up to five-thousand dollars (\$5,000.00), without regard to where

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the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.

(c) Before attempting to validate a ~~winning~~ ticket, the Retailer should instruct the Claimant to ~~write~~ print their name on the back of the ticket and sign their name in the space provided.

(d) Retailer must establish that the ticket is a winning ticket by using the OLC validation procedures/system. If the retailer does not receive the appropriate authorization to pay, the ticket should be returned to the claimant with instructions to file a claim with OLC.

(e) After validating and paying a winning instant game ticket, the retailer should deface the ticket in a manner sufficient to prevent subsequent attempts to claim the ticket prize amount.

(f) For prizes greater than \$600, retailers will provide claimants with OLC claim forms, if available, or direct them to an authorized claim center, the OLC office, or the OLC website.

(g) A retailer shall not charge any player or claimant a fee for selling a ticket, validating a winning ticket, paying a winning ticket, verifying a non-winning ticket, providing a claim form, or for any other assistance not authorized by OLC.

(h) If a claimant of a winning ticket is less than 18 years of age, retailers must instruct the claimant that the Act prohibits prize payment to any person 18 year of age or under and return the ticket to the claimant.

429:10-1-8. Minimum sales requirement

(a) The OLC will establish minimum weekly instant and/or online sales requirements which will be communicated to retailers. Failure to achieve these minimum weekly sales levels may result in suspension or cancellation of the retailer's contract at the sole discretion of OLC.

(b) In order to promote and maintain the availability of lottery retailers in remote and/or sparsely populated areas of the state, and to provide for the continuing operation of seasonal retailers, OLC may waive these minimum sales requirements at OLC's sole discretion.

429:10-1-10. Settlement and retailer invoicing

(a) The accounting period for purposes of preparing retailer invoices shall be weekly from ~~Sunday~~ Saturday at 12:00 midnight through the following ~~Sunday at 12:00 midnight~~ Saturday at 11:59:59 p.m.

(b) All packs of instant tickets activated in an accounting period and for which the prize validation requirements specified in (c) of this Section have occurred, and all sales of online game tickets occurring within the accounting period will be invoiced to the retailer, less any retailer commissions and/or OLC authorized adjustments. The retailer invoice will be available through the OLC lottery sales terminal after ~~5:00 a.m.~~ 4:00 a.m. on Monday, immediately following the end of the accounting period.

(c) For instant games, all ticket packs activated by the retailer or by the OLC on behalf of the retailer for which eighty percent (80%) of the winning low-tier tickets contained in the

pack have been validated by the end of the previous accounting period will be included in the current retailer weekly invoice. Any pack which has been activated for a period of forty-five (45) days will be invoiced to the retailer, even if eighty percent (80%) of the pack's winning low-tier tickets have not been validated. In the event a retailer activates concurrently two or more instant game packs from the same game, the first pack activated will be included in the current retailer weekly invoice regardless of how many low-tier tickets have been validated from the first, except in situations where the retailer has two or more selling locations within the same retail business, in which case the first pack activated will be included in the current retailer weekly invoice when the third or subsequent pack of that game is activated, regardless of how many low-tier tickets have been validated from the first pack.

(d) The retailer invoice will provide a calculation of the proceeds due the OLC. The proceeds will be equal to the retail value of instant game ticket packs, plus the retail value of on-line ticket sales, less applicable sales or cashing commissions, less any winning tickets paid by the retailer during the accounting period, plus or minus any adjustments to the retailer account authorized by OLC.

(e) For purposes of calculating the retailer invoice, free ticket prizes validated by the retailer shall have the same value as the applicable retail value of free ticket(s) provided to the claimant.

[OAR Docket #07-688; filed 4-5-07]

TITLE 429. OKLAHOMA LOTTERY COMMISSION CHAPTER 15. INSTANT GAMES

[OAR Docket #07-689]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

429:15-1-2 [AMENDED]

429:15-1-11 [AMENDED]

AUTHORITY:

Oklahoma Lottery Commission, Board of Trustees, 3A O.S., Section 710

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December 21, 2006

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December 21, 2006

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December 21, 2006

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January 22, 2007

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Failure of the Legislature to disapprove the rules resulted in approval on March 27, 2007

Final adoption:

March 27, 2007

Effective:

May 12, 2007

SUPERSEDED EMERGENCY ACTIONS:

None

INCORPORATIONS BY REFERENCE:

None

ANALYSIS:

The proposed rule amendments add a definition for seasonal retailer in order to keep the definitions in all Title 429 chapters consistent (rules relating to a seasonal retailer are in Chapter 10 of Title 429). This will allow a seasonal retailer to remain a lottery retailer even though sales may not meet minimum sales requirements in the off-seasons. The rules require the completion of a game report within forty-five (45) days of the expiration date of the game's prize claim period and the report shall be posted on the Lottery web site.

CONTACT PERSON:

Rollo Redburn, Administrative Rules Liaison, (405) 522-7700, Oklahoma Lottery Commission, 3817 N. Santa Fe, Suite 175, Oklahoma City, OK 73118-8508; or, Terri Jackson, Administrative Assistant, (405) 522-7700, Oklahoma Lottery Commission, 3817 N. Santa Fe, Suite 175, Oklahoma City, OK 73118-8508.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 12, 2007:

429:15-1-2. Definitions

In addition to terms defined in the Oklahoma Education Lottery Act, the following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

"**Act**" means the Oklahoma Education Lottery Act.

"**Active Game**" means a lottery game currently available for sale from the Oklahoma Lottery Commission.

"**Activated Pack**" means the status of a pack of tickets which indicates to the OLC that tickets are being sold from that pack.

"**Altered Ticket**" means any ticket intentionally changed by a player or by other persons or means in an attempt to make the ticket appear as a winning ticket.

"**Authorized Location**" means a business authorized by a contract with OLC to sell OLC Lottery products. "**Authorized Location**" and "**Authorized Retailer**" are synonymous terms.

"**Automatic Win Symbol**" means any symbol that, when revealed under the removable covering on an instant ticket, automatically wins a prize for the player.

"**Breaks**" means a gap of one or more numbered instant tickets in a pack number sequence.

"**Cancelled Ticket**" means any OLC ticket for which the ticket sale and/or validation information has been deleted from OLC records.

"**Caption**" means the letters appearing near the play symbols in the instant ticket play area that verify the correctness of play symbols.

"**Certified Drawing**" means a drawing in which the lottery and an independent accountant attests that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.

"**Claim Center**" means an OLC authorized location available to pay claims for prizes of more than \$600. A "Claim Center" may also be a retailer authorized by the Board to pay

prizes up to five thousand dollars (\$5,000.00) without regard to where the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.

"**Claim Form**" means the printed form authorized by OLC that a player shall complete and submit to OLC along with a ticket to determine eligibility for prize payment, in the event that such prize has not been validated and paid by an OLC retailer.

"**Claimant**" means a player who has submitted a claim for prize payment.

"**Claim Period**" means the period of time prescribed by the Act during which players must claim cash prizes. For instant games, the claim period is ninety (90) days after the announced end of the game. For online games, the claim period is one hundred eighty (180) days after the drawing date.

"**Computer Selected Items**" means numbers or groups of numbers selected for a player by the computer in online games. Also known as auto picks, quick picks, or computer picks.

"**Counterfeit Ticket**" means any ticket not produced by an OLC authorized ticket printer or an OLC online games sales terminal.

"**Defectively Printed Tickets**" means the same as misregistered ticket.

"**Display Printing**" means the printing on the ticket not associated with the ticket game play.

"**District Office**" means an OLC claim center, if any, in various cities in Oklahoma.

"**Disputed Ticket**" means a ticket which the claimant believes is a prize winning ticket, but which fails OLC validation procedures.

"**Doubler**" means any method used on a ticket to double a prize amount.

"**Draw Procedures**" means the written document approved by OLC that specifies the process for selecting winners for a particular instant game or instant game promotion, if a drawing is designed as part of the game or promotion, and for each online game or online game promotion.

"**Drawing**" means the process by which the lottery randomly selects numbers or items in accordance with the specific game rules or game promotion rules for those games or game promotions requiring random selection of numbers or items.

"**Duplicate Ticket**" means a ticket produced by photograph, xerography or any other duplication method other than an authorized instant ticket printed for OLC or generated by an authorized online terminal.

"**Electronic Funds Transfer**" or "**EFT**" means the process by which the OLC transfers funds from a retailer authorized bank account to pay amounts due the OLC or by which OLC provides funds to a retailer for payment of prizes.

"**Entry**" means a lottery ticket or other OLC authorized document submitted to OLC or any OLC authorized party for participation in an OLC drawing.

"**Executive Director**" means the chief executive officer and administrator of the Oklahoma Lottery Commission.

"**Finalist**" means a person selected through a preliminary drawing for participation in a grand prize drawing.

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"Floating Image Play Area" means the play area of each instant ticket which may print in a slightly different position on game tickets as a security measure.

"Game Board" means a pre-printed OLC form for use by players in selecting numbers for online games (see "Play Slip").

"Game Name" means the name of the Instant or Online game, as specified in the game procedures.

"Game Number" means the preprinted number on an instant ticket which identifies a particular game.

"Game Report" means a report prepared after a game end showing, at a minimum, the number of tickets sold and the number of prizes awarded in the game.

"Game Specifications Document" means the same as working papers.

"Grand Prize Drawing" means an event in which qualified players/contestants are awarded prizes in a random manner and as provided in OLC approved procedures.

"High-Tier Prize" means a prize of \$601 or more.

"Instant Game" means an instant ticket lottery game offered by OLC for sale to the public that is played by revealing a hidden play area on a ticket to display the play symbols.

"Instant Game Procedures" means the document summarizing the game specifications as provided in the working papers for each Instant Game.

"Instant Game Promotion Procedures" means the OLC approved procedures for player participation in any Instant Game Promotion.

"Jackpot" means a large prize; often the top prize in an online game.

"Lottery Retailer" or **"Retailer"** means a business entity contracted to OLC to sell lottery tickets.

"Low-Tier Prize" means a prize of twenty-five dollars (\$25) or less.

"Mid-Tier Prize" means a prize of \$25.01-\$600.

"Minor" means an individual younger than 18 years of age.

"Miscut Ticket" means a ticket cut during production such that the ticket is not whole and able to be validated.

"Misregistered Ticket" means any ticket on which printed data has been misprinted in such a manner as to prevent reading during the validation process.

"Mutilated Ticket" means any lottery ticket accidentally or intentionally damaged such that completion of OLC validation procedures is not possible.

"Non-Cash Prize" means merchandise prizes offered in lottery games or lottery promotions.

"Oklahoma Lottery Retailer Contract" means Parts 1 through 8 of the Lottery Retailer Sales Contract Application, Title 3A, Section 701 ff of the Oklahoma Statutes as amended, Emergency and Permanent Rules approved by the OLC Board. As used in these Rules the terms, **"Retailer Contract," "Oklahoma Ticket Sales Contract," "Lottery Retail Sales Contract,"** and **"Lottery Retailer Sales Contract"** all mean **"Oklahoma Lottery Retailer Contract"**.

"OLC" means the Oklahoma Lottery Commission.

"Online Game" means a game where tickets or shares are purchased through a network of sales terminals located at OLC authorized retail outlets through use of an OLC authorized play slip or manual retailer input of player requested numbers. "Online Game" does not include a game played via the Internet.

"Online Game Procedures" means the document summarizing game specifications for each online game offered for sale by OLC.

"Online Game Promotion Procedures" means the document summarizing promotion specifications for each online game promotion offered by OLC.

"Online Terminal" means the OLC authorized sales terminal used to sell various online lottery number games.

"Pack" or **"Pack Size"** means a package of instant tickets, each ticket with a different number. The number of tickets in a pack is generally from 60 to 500.

"Pack Number" means the unique number on the ticket that designates each pack of instant tickets in the game. Each pack number is unique within each instant game.

"Play Area" means the covered area of an instant ticket that contains the ticket play symbols.

"Play Central ® Lottery Kiosk" means a self-service ticket vending machine that allows the player to purchase instant tickets and/or online game tickets without any clerk assistance.

"Play Panel" means an area on an online game play slip or game board used by a player to select numbers for a single online game play.

"Play Slip" means a pre-printed OLC form for use by players in selecting numbers for online games (see game board).

"Play Spot" means an authorized area on an instant ticket containing one play symbol and one caption.

"Play Station" means a stand-alone unit provided by OLC for the display of lottery game brochures play slips, etc.

"Play Style" means the method of play to determine a winner for an individual game or game promotion.

"Play Symbol" means the printed data under the removable covering on the front of an instant ticket that is used to determine eligibility for a prize. The symbols for individual games will be specified in individual instant game procedures.

"Player-Selected Item" means a number or item or group of numbers or items selected by a player in connection with an online game.

"Point of Sale Material" or **"POS"** means flyers, brochures, posters and signage used within/at lottery retail locations to identify the products and games available for sale, as well as to provide general information (i.e. odds, jackpot amounts, prize levels and beneficiaries). **"Point of Purchase Material"** or **"POP"** is synonymous with POS.

"Preliminary Drawing" means an event for the selection of contestants for a grand prize drawing.

"Price Point" means the retail selling price of an individual game ticket.

"Printer Omitted Tickets" means any tickets designated by OLC's instant ticket printer as having been omitted from the ticket order quantity for reasons stated by the ticket printer.

"Prize" means a cash amount or product (merchandise) that can be won in a lottery game or game promotion.

"Prize Drawing" means a method for determining game or game promotion winners, as defined in OLC procedures.

"Prize Structure" means the number, value, and odds of winning prizes for an individual game as approved by OLC in individual game procedures.

"Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract.

"Retailer Commission" means the amount of money paid to retailers for selling lottery products.

"Retailer Paid Prizes" means prizes which may be paid by retailers subject to OLC validation procedures.

"Retail Sales Price" means the OLC designated price OLC retailers must charge for a ticket when sold.

"Retailer Ticket Order Quantity" means the number of tickets or packs of tickets ordered by the retailer from OLC or its authorized distributor.

"Retailer Validation Code" means the code found under the covered area over the play symbols on the front of the instant ticket which the OLC retailer may use to verify and validate low-tier winners.

"Seasonal Retailer" means a business which sells Lottery tickets or shares on behalf of OLC pursuant to a retailer contract and whose business may be closed for some portion of the year and/or whose business hours may be significantly reduced for some portion of the year due to the seasonal nature of the business. Businesses that are closed temporarily for remodeling, change of ownership, or similar temporary closings will not be deemed to be seasonal retailers.

"Settled Pack" means the status of an activated pack of instant tickets when the OLC has invoiced the retailer based upon a pre-determined formula or schedule and the retailer has paid for the pack.

"Share" means any intangible evidence of participation in a lottery game.

"Ticket" means any tangible evidence issued by the lottery to provide participation in a lottery game or drawing authorized by the Act.

"Ticket Number" means the number on the ticket that refers to the ticket sequence within the pack.

"Ticket Order Quantity" means the number of tickets or packs of tickets ordered by OLC from the instant ticket printer.

"Unreadable Ticket" means any ticket on which any play data or other ticket validation information cannot be read as part of the prize validation procedure.

"Validation Number" means the unique data printed on a ticket that enables verification of the ticket as a valid winner.

"Validation Procedures" means the procedures utilized by OLC and/or its authorized vendors to determine if a claimed ticket is a valid winner.

"Valid Ticket" means a ticket which meets all OLC game specifications and OLC validation requirements.

"Variant" means a symbol used in conjunction with certain play styles and may include a symbol that serves as a "wild card" to complete a winning combination of play symbols.

"VIRN (Void If Removed Numbers)" means a series of numbers under the removable covering on an instant ticket to be used in the validation process.

"Wild" means a symbol or word, different from all the others in an instant game, used to complete a match on a winning ticket.

"Working Papers" means the written document approved by the OLC for instant game production that includes, among other things, the game name, the art work for the front and back of the ticket, how a prize is won, game prize structure, play style, ticket delivery schedule to OLC, and eligibility for a drawing, if any.

429:15-1-11. Game report

Following the time period in which prizes may be claimed after termination of a game, the OLC shall prepare a report that shows, at a minimum, the total number of tickets sold and the number of prizes awarded in the game. Such report shall be completed within forty-five (45) days of the expiration date of the game's prize claim period and shall be posted on the OLC web-site.

[OAR Docket #07-689; filed 4-5-07]

**TITLE 429. OKLAHOMA LOTTERY COMMISSION
CHAPTER 20. ONLINE GAMES**

[OAR Docket #07-690]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

429:20-1-2 [AMENDED]

429:20-1-12 [AMENDED]

AUTHORITY:

Oklahoma Lottery Commission, Board of Trustees, 3A O.S., Section 710

DATES:

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SUPERSEDED EMERGENCY ACTIONS:

None

INCORPORATIONS BY REFERENCE:

None

Permanent Final Adoptions

ANALYSIS:

The proposed rule amendments add a definition for seasonal retailer in order to keep the definitions in all Title 429 chapters consistent (rules relating to a seasonal retailer are in Chapter 10 of Title 429). This will allow a seasonal retailer to remain a lottery retailer even though sales may not meet minimum sales requirements in the off-seasons. The rules require the completion of a game report within forty-five (45) days of the expiration date of the game's prize claim period and the report shall be posted on the Lottery web site.

CONTACT PERSON:

Rollo Redburn, Administrative Rules Liaison, (405) 522-7700, Oklahoma Lottery Commission, 3817 N. Santa Fe, Suite 175, Oklahoma City, OK 73118-8508; or, Terri Jackson, Administrative Assistant, (405) 522-7700, Oklahoma Lottery Commission, 3817 N. Santa Fe, Suite 175, Oklahoma City, OK 73118-8508.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 12, 2007:

429:20-1-2. Definitions

In addition to terms defined in the Oklahoma Education Lottery Act, the following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

"Act" means the Oklahoma Education Lottery Act.

"Active Game" means a lottery game currently available for sale from the Oklahoma Lottery Commission.

"Activated Pack" means the status of a pack of tickets which indicates to the OLC that tickets are being sold from that pack.

"Altered Ticket" means any ticket intentionally changed by a player or by other persons or means in an attempt to make the ticket appear as a winning ticket.

"Authorized Location" means a business authorized by a contract with OLC to sell OLC Lottery products. **"Authorized Location"** and **"Authorized Retailer"** are synonymous terms.

"Automatic Win Symbol" means any symbol that, when revealed under the removable covering on an instant ticket, automatically wins a prize for the player.

"Breaks" means a gap of one or more numbered instant tickets in a pack number sequence.

"Cancelled Ticket" means any OLC ticket for which the ticket sale and/or validation information has been deleted from OLC records.

"Caption" means the letters appearing near the play symbols in the instant ticket play area that verify the correctness of play symbols.

"Certified Drawing" means a drawing in which the lottery and an independent accountant attests that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.

"Claim Center" means an OLC authorized location available to pay claims for prizes of more than \$600. A "Claim Center" may also be a retailer authorized by the Board to pay prizes up to five thousand dollars (\$5,000.00) without regard to where the ticket or share was purchased, after performing

validation procedures appropriate to the game and as specified by the Board.

"Claim Form" means the printed form authorized by OLC that a player shall complete and submit to OLC along with a ticket to determine eligibility for prize payment, in the event that such prize has not been validated and paid by an OLC retailer.

"Claimant" means a player who has submitted a claim for prize payment.

"Claim Period" means the period of time prescribed by the Act during which players must claim cash prizes. For instant games, the claim period is ninety (90) days after the announced end of the game. For online games, the claim period is one hundred eighty (180) days after the drawing date.

"Computer Selected Items" means numbers or groups of numbers selected for a player by the computer in online games. Also known as auto picks, quick picks, or computer picks.

"Counterfeit Ticket" means any ticket not produced by an OLC authorized ticket printer or an OLC online games sales terminal.

"Defectively Printed Tickets" means the same as misregistered ticket.

"Display Printing" means the printing on the ticket not associated with the ticket game play.

"District Office" means an OLC claim center, if any, in various cities in Oklahoma.

"Disputed Ticket" means a ticket which the claimant believes is a prize winning ticket, but which fails OLC validation procedures.

"Doubler" means any method used on a ticket to double a prize amount.

"Draw Procedures" means the written document approved by OLC that specifies the process for selecting winners for a particular instant game or instant game promotion, if a drawing is designed as part of the game or promotion, and for each online game or online game promotion.

"Drawing" means the process by which the lottery randomly selects numbers or items in accordance with the specific game rules or game promotion rules for those games or game promotions requiring random selection of numbers or items.

"Duplicate Ticket" means a ticket produced by photograph, xerography or any other duplication method other than an authorized instant ticket printed for OLC or generated by an authorized online terminal.

"Electronic Funds Transfer" or **"EFT"** means the process by which the OLC transfers funds from a retailer authorized bank account to pay amounts due the OLC or by which OLC provides funds to a retailer for payment of prizes.

"Entry" means a lottery ticket or other OLC authorized document submitted to OLC or any OLC authorized party for participation in an OLC drawing.

"Executive Director" means the chief executive officer and administrator of the Oklahoma Lottery Commission.

"Finalist" means a person selected through a preliminary drawing for participation in a grand prize drawing.

"Floating Image Play Area" means the play area of each instant ticket which may print in a slightly different position on game tickets as a security measure.

"Game Board" means a pre-printed OLC form for use by players in selecting numbers for online games (see "Play Slip").

"Game Name" means the name of the Instant or Online game, as specified in the game procedures.

"Game Number" means the preprinted number on an instant ticket which identifies a particular game.

"Game Report" means a report prepared after a game end showing, at a minimum, the number of tickets sold and the number of prizes awarded in the game.

"Game Specifications Document" means the same as working papers.

"Grand Prize Drawing" means an event in which qualified players/contestants are awarded prizes in a random manner and as provided in OLC approved procedures.

"High-Tier Prize" means a prize of \$601 or more.

"Instant Game" means an instant ticket lottery game offered by OLC for sale to the public that is played by revealing a hidden play area on a ticket to display the play symbols.

"Instant Game Procedures" means the document summarizing the game specifications as provided in the working papers for each Instant Game.

"Instant Game Promotion Procedures" means the OLC approved procedures for player participation in any Instant Game Promotion.

"Jackpot" means a large prize; often the top prize in an online game.

"Lottery Retailer" or **"Retailer"** means a business entity contracted to OLC to sell lottery tickets.

"Low-Tier Prize" means a prize of twenty-five dollars (\$25) or less.

"Mid-Tier Prize" means a prize of \$25.01-\$600.

"Minor" means an individual younger than 18 years of age.

"Miscut Ticket" means a ticket cut during production such that the ticket is not whole and able to be validated.

"Misregistered Ticket" means any ticket on which printed data has been misprinted in such a manner as to prevent reading during the validation process.

"Mutilated Ticket" means any lottery ticket accidentally or intentionally damaged such that completion of OLC validation procedures is not possible.

"Non-Cash Prize" means merchandise prizes offered in lottery games or lottery promotions.

"Oklahoma Lottery Retailer Contract" means Parts 1 through 8 of the Lottery Retailer Sales Contract Application, Title 3A, Section 701 ff of the Oklahoma Statutes as amended, Emergency and Permanent Rules approved by the OLC Board. As used in these Rules the terms, **"Retailer Contract," "Oklahoma Ticket Sales Contract," "Lottery Retail Sales Contract,"** and **"Lottery Retailer Sales Contract"** all mean **"Oklahoma Lottery Retailer Contract"**.

"OLC" means the Oklahoma Lottery Commission.

"Online Game" means a game where tickets or shares are purchased through a network of sales terminals located at OLC authorized retail outlets through use of an OLC authorized play

slip or manual retailer input of player requested numbers. "Online Game" does not include a game played via the Internet.

"Online Game Procedures" means the document summarizing game specifications for each online game offered for sale by OLC.

"Online Game Promotion Procedures" means the document summarizing promotion specifications for each online game promotion offered by OLC.

"Online Terminal" means the OLC authorized sales terminal used to sell various online lottery number games.

"Pack" or **"Pack Size"** means a package of instant tickets, each ticket with a different number. The number of tickets in a pack is generally from 60 to 500.

"Pack Number" means the unique number on the ticket that designates each pack of instant tickets in the game. Each pack number is unique within each instant game.

"Play Area" means the covered area of an instant ticket that contains the ticket play symbols.

"Play Central[®] Lottery Kiosk" means a self-service ticket vending machine that allows the player to purchase instant tickets and/or online game tickets without any clerk assistance.

"Play Panel" means an area on an online game play slip or game board used by a player to select numbers for a single online game play.

"Play Slip" means a pre-printed OLC form for use by players in selecting numbers for online games (see game board).

"Play Spot" means an authorized area on an instant ticket containing one play symbol and one caption.

"Play Station" means a stand-alone unit provided by OLC for the display of lottery game brochures play slips, etc.

"Play Style" means the method of play to determine a winner for an individual game or game promotion.

"Play Symbol" means the printed data under the removable covering on the front of an instant ticket that is used to determine eligibility for a prize. The symbols for individual games will be specified in individual instant game procedures.

"Player-Selected Item" means a number or item or group of numbers or items selected by a player in connection with an online game.

"Point of Sale Material" or **"POS"** means flyers, brochures, posters and signage used within/at lottery retail locations to identify the products and games available for sale, as well as to provide general information (i.e. odds, jackpot amounts, prize levels and beneficiaries).

"Point of Purchase Material" or **"POP"** is synonymous with POS.

"Preliminary Drawing" means an event for the selection of contestants for a grand prize drawing.

"Price Point" means the retail selling price of an individual game ticket.

"Printer Omitted Tickets" means any tickets designated by OLC's instant ticket printer as having been omitted from the ticket order quantity for reasons stated by the ticket printer.

"Prize" means a cash amount or product (merchandise) that can be won in a lottery game or game promotion.

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"Prize Drawing" means a method for determining game or game promotion winners, as defined in OLC procedures.

"Prize Structure" means the number, value, and odds of winning prizes for an individual game as approved by OLC in individual game procedures.

"Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract.

"Retailer Commission" means the amount of money paid to retailers for selling lottery products.

"Retailer Paid Prizes" means prizes which may be paid by retailers subject to OLC validation procedures.

"Retail Sales Price" means the OLC designated price OLC retailers must charge for a ticket when sold.

"Retailer Ticket Order Quantity" means the number of tickets or packs of tickets ordered by the retailer from OLC or its authorized distributor.

"Retailer Validation Code" means the code found under the covered area over the play symbols on the front of the instant ticket which the OLC retailer may use to verify and validate low-tier winners.

"Seasonal Retailer" means a business which sells Lottery tickets or shares on behalf of OLC pursuant to a retailer contract and whose business may be closed for some portion of the year and/or whose business hours may be significantly reduced for some portion of the year due to the seasonal nature of the business. Businesses that are closed temporarily for remodeling, change of ownership, or similar temporary closings will not be deemed to be seasonal retailers.

"Settled Pack" means the status of an activated pack of instant tickets when the OLC has invoiced the retailer based upon a pre-determined formula or schedule and the retailer has paid for the pack.

"Share" means any intangible evidence of participation in a lottery game.

"Ticket" means any tangible evidence issued by the lottery to provide participation in a lottery game or drawing authorized by the Act.

"Ticket Number" means the number on the ticket that refers to the ticket sequence within the pack.

"Ticket Order Quantity" means the number of tickets or packs of tickets ordered by OLC from the instant ticket printer.

"Unreadable Ticket" means any ticket on which any play data or other ticket validation information cannot be read as part of the prize validation procedure.

"Validation Number" means the unique data printed on a ticket that enables verification of the ticket as a valid winner.

"Validation Procedures" means the procedures utilized by OLC and/or its authorized vendors to determine if a claimed ticket is a valid winner.

"Valid Ticket" means a ticket which meets all OLC game specifications and OLC validation requirements.

"Variant" means a symbol used in conjunction with certain play styles and may include a symbol that serves as a "wild card" to complete a winning combination of play symbols.

"VIRN (Void If Removed Numbers)" means a series of numbers under the removable covering on an instant ticket to be used in the validation process.

"Wild" means a symbol or word, different from all the others in an instant game, used to complete a match on a winning ticket.

"Working Papers" means the written document approved by the OLC for instant game production that includes, among other things, the game name, the art work for the front and back of the ticket, how a prize is won, game prize structure, play style, ticket delivery schedule to OLC, and eligibility for a drawing, if any.

429:20-1-12. Game report

Following the time period in which prizes may be claimed after termination of a game, the OLC shall prepare a report that shows, at a minimum, the total number of tickets sold and the number of prizes awarded in the game. Such report shall be completed within forty-five (45) days of the expiration date of the game's prize claim period and shall be posted on the OLC web-site.

[OAR Docket #07-690; filed 4-5-07]

TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION CHAPTER 15. PHYSICIAN ASSISTANTS

[OAR Docket #07-613]

RULEMAKING ACTION:

PERMANENT final adoption.

RULES:

Subchapter 3. Licensure of Physician Assistants

435:15-3-1. Application for licensure [AMENDED]

435:15-3-18. License renewal period; reinstatement [AMENDED]

Subchapter 11. Prescriptive Guidelines and Drug Formulary

435:15-11-1. Prescriptive and dispensing authority [AMENDED]

AUTHORITY:

Title 59 O.S., Section 519.3, Board of Medical Licensure and Supervision

DATES:

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September 15, 2006 to October 16, 2006

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Failure of the Legislature to disapprove the rule(s) resulted in approval on March 27, 2007.

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July 1, 2007

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATED BY REFERENCE:

n/a

ANALYSIS:

The application requirements are being amended to specify what the physician assistant program should consist of and to require a jurisprudence examination to be passed for both initial licensure and renewal/reinstatement

of licensure. The prescriptive guidelines are being amended to change the amount of schedules III, IV and V controlled medications that may be prescribed by physician assistants.

CONTACT PERSON:

Jan Ewing, Deputy Director, 405-848-6841, #104

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2007:

SUBCHAPTER 3. LICENSURE OF PHYSICIAN ASSISTANTS

435:15-3-1. Application for licensure

(a) A Physician Assistant license shall only be issued by the Board upon application filed by the physician assistant.

(b) All applicants for Physician Assistant licenses shall meet the following qualifications:

(1) ~~Graduation~~ Graduate from an accredited Physician Assistant Program ~~recognized by the Board~~ consisting of at least one year of classroom instruction and one year of clinical experience that includes a minimum of one month each in family medicine, emergency medicine and surgery.

(2) A passing score on the Physician Assistant National Certifying Examination administered by the National Commission on the Certification of Physician Assistants, or its successor. The Board may recognize another national examination to determine the qualifications of the applicant to practice as a physician assistant when such examination has documented its ability to measure such skills and abilities. The applicant must bear the cost of the examination.

(3) The applicant shall take and complete the jurisprudence examination prepared by the staff. Seventy-five percent (75%) or above shall be a passing grade. The examination shall cover the Act and any other significant statute, rule or material related to practice as a Physician Assistant in this state. The applicant shall be provided a copy of all statutes, rules or other material from which the examination was created and may review such material while taking the jurisprudence examination. An applicant who fails the jurisprudence examination three (3) times shall be required to meet with the Secretary in order to devise a study plan prior to taking the jurisprudence examination again. The Board has determined that the jurisprudence examination is an integral part of the application process. A passing score on the jurisprudence examination is a requirement for licensure.

(3)4 Applicants must be of good moral character.

(4)5 Applicants must meet other requirements as determined by the Board.

435:15-3-18. License renewal period; reinstatement

(a) Renewal of a Physician Assistant license is due on or before March 31 of each calendar year.

(b) Failure to renew by March 31 renders the license inactive and no health care services may be performed by a physician assistant.

(c) Between April 1 and April 30 of each year, renewal of a Physician Assistant license shall require the applicant to pay the annual renewal fee and a late renewal fee of one half of the sum of the renewal fee.

(d) Between May 1 and May 31 of each year, the renewal of a Physician Assistant license shall require the applicant to pay the annual renewal fee, initial application processing fee, and a late renewal fee equal to the sum of the renewal fee and the initial application processing fee.

(e) After May 31 of each year, an appropriate application for reinstatement must be filed with and approved by the Board along with payment of an initial application processing fee.

(f) The renewal application shall require notification to the Board of any changes that have occurred in the application to practice during the previous calendar year.

(g) At the time of renewal, the applicant shall take and complete the jurisprudence examination prepared by the staff. Seventy-five percent (75%) or above shall be a passing grade. The examination shall cover the Act and any other significant statute, rule or material related to practice as a Physician Assistant in this state. The applicant shall be provided a copy of all statutes, rules or other material from which the examination was created and may review such material while taking the jurisprudence examination. The license will not be renewed until a successful score is received on the jurisprudence examination.

SUBCHAPTER 11. PRESCRIPTIVE GUIDELINES AND DRUG FORMULARY

435:15-11-1. Prescriptive and dispensing authority

(a) A physician assistant who is recognized by the Board to prescribe under the direction of a supervising physician and is in compliance with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of professional practice only, may issue written and oral prescriptions and orders for medical supplies, services and drugs, including controlled medications in Schedules III, IV, and V pursuant to 63 O.S. §2-312 as delegated by the supervising physician and as approved in the Physician Assistant Drug Formulary (OAC 435:15-11-2).

(b) Any prescription for a pure form or combination of the following generic classes of drugs, listed in 435:15-11-2, may be prescribed, unless the drug or class of drugs is listed as excluded. Written prescriptions for drugs or classes of drugs that are excluded may be transmitted, only with the direct order of the supervising physician.

(c) Prescriptions for non-controlled medications are limited to a 30-day supply with two (2) refills of an agent prescribed for ~~the first time for a patient~~ a new diagnosis. For a ~~chronic, stable condition~~ a 90 day supply with three (3) refills patients

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with an established diagnosis, up to a 90 day supply with refills up to one year can be written and signed, or called into a pharmacy by a physician assistant.

(d) Prescriptions for Schedules III, IV and V controlled medications are limited to a ~~10 day supply or 40 dosage units with one (1) refill, whichever is smaller~~ thirty (30) day supply with no refills. In order for a physician assistant to prescribe a controlled substance in an out-patient setting, the physician assistant must be currently registered with the Drug Enforcement Administration and Oklahoma Bureau of Narcotics and Dangerous Drugs.

(e) A physician assistant may write an order for a Schedule II drug for immediate or ongoing administration on site. Prescriptions and orders for Schedule II drugs written by a physician assistant must be included on a written protocol determined by the supervising physician and approved by the medical staff committee of the facility or by direct verbal order of the supervising physician. In order for a physician assistant to prescribe and order a Schedule II controlled substance for immediate or ongoing administration on site, the physician assistant must be currently registered with the Drug Enforcement Administration and Oklahoma Bureau of Narcotics and Dangerous Drugs.

(f) A prescription issued by a physician assistant, whether written or oral, shall be the joint responsibility of the physician assistant and supervising physician. The supervising physician shall be responsible for the formulation and/or approval of all orders and protocols which allow the physician assistant to issue prescriptions. Questions concerning a prescription may be directed either to the supervising physician whose name shall appear on the prescription blank or to the physician assistant.

(g) All new drug entities will be restricted from the Drug Formulary, listed in 435:15-11-2, and added, if at all, only after review and approval by the Oklahoma State Board of Pharmacy and the Committee, and subsequent approval by the Board. This restriction shall not apply to modifications of current generic drugs included on the Drug Formulary.

(h) Physician Assistants may not dispense drugs, but may request, receive and sign for professional samples and may distribute professional samples directly to patients in accordance with written policies established by the supervising physician.

(i) Physician assistants practicing in patient care settings that are part of the State Department of Health, State Department of Mental Health, or other special patient care settings designated by the Board are permitted to dispense medications directly to patients as directed by the supervising physician in written protocol, standing or direct order. Except for samples, Physician assistants may not dispense drugs in any other practice care setting.

[OAR Docket #07-613; filed 4-2-07]

TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION CHAPTER 30. OCCUPATIONAL THERAPISTS AND ASSISTANTS

[OAR Docket #07-614]

RULEMAKING ACTION:

PERMANENT final adoption.

RULES:

435:30-1-4. Licensure by endorsement [AMENDED]

435:30-1-5. License renewal; late fees; continuing education; re-entry guidelines [AMENDED]

AUTHORITY:

Title 59 O.S., Section 888.14, Board of Medical Licensure and Supervision

DATES:

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May 11, 2007

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATED BY REFERENCE:

n/a

ANALYSIS:

The National Board for Certification in Occupational Therapy has assumed the examination services from the American Occupational Therapy Association. Rule 435:30-1-4 was amended to require those applying for licensure by endorsement to have passed a written examination where the examination and grade standard were that of the National Board for Certification in Occupational Therapy. Amendments also allow the Committee and Board to require proof of continued competence if it has been more than five years since passing the examination. Amendments to Rule 435:30-1-5 accept programs offered or approved by the National Board of Certification in Occupational Therapy for continuing education and changes the AOTCB licensure examination to the NBCOT certification examination under the re-entry guidelines.

CONTACT PERSON:

Jan Ewing, Deputy Director, 405-848-6841, #104

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

435:30-1-4. Licensure by endorsement

Requirements for licensure by endorsement for Occupational Therapists or Occupational Therapy Assistants are as follows:

- (1) Applicants for licensure by endorsement must meet all statutory requirements required of applicants for licensure by examination, as set forth in the Act.

(2) Any person who is currently licensed by examination as an occupational therapist or occupational therapy assistant in another state of the United States of America, the District of Columbia or Puerto Rico, is eligible for licensure by endorsement provided the written examination and grade standard were that of the ~~American Occupational Therapy Association National Board for Certification in Occupational Therapy~~ or any other group approved by the Board. Submission of proof of ~~possession of a Registration Card by the American Occupational Therapy Association shall be considered proof of having passed an approved examination, or scores may be submitted through a reporting service approved by the Board.~~ ~~Absence of a Registration Card will require a letter by the American Occupational Therapy Association indicating presence on their registry of previous qualification by that association having passed the licensure examination shall be required.~~ If the applicant has not been employed as an occupational therapist or occupational therapy assistant during the year prior to application, such applicant may be requested to present himself/herself for a personal interview with the members of the Advisory Committee or the Board.

(3) Applicants who have not taken and passed the approved licensure examination within the past five years may be required to provide proof of continued competence as evidenced by one or more of the following:

(A) Continuing education consisting of up to two hours for each month out of practice, obtained with the last two years and approved by the Committee;

(B) Practice under the direct supervision of a licensed Occupational Therapist for one to three months. The supervising Therapist will provide to the Committee a report on the applicant's performance prior to licensure;

(C) Retake the approved licensure examination.

~~(34) The completed application form must be submitted to the Board office accompanied by fees as set by the Board. Should the application be denied because the applicant has not met all the requirements for eligibility for licensure, the license fee shall be refunded upon written notice from the applicant that he/she does not wish his/her application to be reprocessed. Should the applicant wish to reapply at a later date, upon completion of all requirements, appropriate fees must be submitted with their application.~~

435:30-1-5. License renewal; late fees; continuing education; re-entry guidelines

(a) **Yearly license renewal.** The occupational therapist and occupational therapy assistant license is required to be renewed yearly on October 31 upon forms provided by the Board and shall be accompanied by fees set by the Board. In addition, late fees shall be assessed as set by the Board.

(b) **Continuing education for renewal.**

(1) Continuing education for renewal of licensure has been established to require therapists' involvement in activities which keep their skills and knowledge of current

practice up to date. A point is the equivalent of 1 contact hour. Twenty contact hours every 2 years will be required.

(2) A Sub-Committee, composed of Occupational Therapists and Occupational Therapy Assistants, may review all points submitted. The Sub-Committee will forward recommendations to the Occupational Therapy Advisory Committee for approval or denial. Reasons for denial will be given to each therapist. Should any individual therapist have questions as to the appropriateness of a program, the therapist could consult the Committee. The Committee would have the authority to decide on any type of program not listed and assign appropriate hours. The responsibility for showing how a particular activity is relevant to maintaining skills as an Occupational Therapist or Occupational Therapy Assistant will be with the therapist applying for approval. The Committee will automatically accept programs offered or approved by the American Occupational Therapy Association or the Oklahoma Occupational Therapy Association as proved courses.

(3) The Committee recognizes the role that ongoing practice plays in maintaining competence as an Occupational Therapist or Occupational Therapy Assistant. Continuing education requirements are designed to update knowledge and skills. Synthesis takes place when the therapist has the opportunity to apply this knowledge and these skills to their practice. Therefore, therapists will be asked to provide information about their practice of occupational therapy at the time of renewal.

(4) Traditional method of points/value/documentation:

(A) Traditional methods of points:

(i) Workshops

(ii) Inservices (6 point maximum per compliance period)

(iii) Seminars

(iv) Conferences

(v) Programs offered by or approved by the American Occupational Therapy Association or the Oklahoma Occupational Therapy Association or the National Board for Certification in Occupational Therapy

(vi) Programs at Special Interest Section meetings

(vii) Occupational Therapy Education Council of Oklahoma workshops (points as assigned on request from Committee)

(B) Assigned Value: 1 point per hour of participation.

(C) Documentation: Verification of attendance and copies of supporting documentation such as program brochure, syllabus, etc. If unable to verify attendance, use Form B **Verification of Conference Attendance**, attach a copy of receipt for conference fee and statement of relevancy to practice of Occupational Therapy if not obvious from the program materials.

(5) Alternative methods of points:

(A) Presentations of occupational therapy programs

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- (4i) Presentations at workshops, seminars, conferences
 - (2ii) Presentations as guest lecturer at accredited occupational therapy curriculum
 - (3iii) Presentations as guest lecturer at other programs on topics related to occupational therapy department inservices
 - (4iv) Assigned Value: 2 points per hour for first presentation of original material. No additional points for subsequent presentations.
 - (5v) Documentation: Copies of supporting documentation such as brochures, programs, or syllabus and a statement of objectives of presentation.
- (B) Clinical Instruction of Occupational Therapist students or Occupational Therapy Assistant students.
- (i) Assigned Value: 1 point per week of continuous direct supervision.
 - (ii) Documentation: Copy of letter of verification of fieldwork from educational program.
- (C) Publications (published or accepted for publication)
- (4i) Authorship or co-authorship of a book relating to occupational therapy:
 - (1) Maximum of 20 points.
 - (2ii) Documentation: Copy of Title page.
 - (2ii) Authorship of a chapter in a book or journal article appearing in a professional journal:
 - (1) Maximum of 10 points.
 - (2ii) Documentation: Copy of table of contents and first page of chapter or article.
 - (3iii) Authorship of an article, book review or abstract in a newsletter (such as OOTA Newsletter, OT Newsweek, SIS Newsletter, or other related newsletters):
 - (1) Maximum of 10 points per compliance period.
 - (2ii) Documentation: Copy of article, book review or abstract evidencing title of newsletter and date of publication.
 - (4iv) Alternative media such as video tapes, slide/tape presentations, etc., that would be available for general viewing. Media or description of media to be submitted to Committee for approval and assignment of points as appropriate.
 - (1) Assigned Value: 10-20 points per publication or finished product
 - (2ii) Documentation: Copy of approval letter from Committee.
- (D) Research
- (4i) Principal or co-investigator, project director or research assistant. Research proposal and final results submitted to Committee for approval:
 - (1) 10 points
 - (2ii) Documentation: Statement of participation and abstract of proposal and results.
 - (2ii) Quality assurance studies completed and published in journal or
 - (1) 5 points Assigned Value: 5-10 points per project
 - (2ii) Documentation: Manuscript acknowledgment or copy of article.
- (E) Formal Coursework
- (4i) College and university coursework courses directly relating to improvement, advancement, or extension of one's skills as an Occupational Therapist. One credit course would be 10 points, 2-credit course 20 points, and 3-credit course would be 30 points. Assigned Value: 10-30 points as approved.
 - (2ii) College or university courses which are indirectly related, yet support skills and knowledge will be evaluated individually and assigned value accordingly.
 - (3iii) Documentation: Course description with statement of relevance to Occupational Therapy and transcript or other documentation of passing grade.
- (F) Self-Study: (Independent Learning Projects). A combination of activities which may include, but are not limited to a combination of reading, observing other therapists, viewing video tapes and quality assurance studies and related professional activities which enhance knowledge and skill in a specific area. A Report of Professional Self-Study should be submitted to Committee for approval (Form C). Points will be assigned by the Committee based on the relevance to practice and complexity. Documentation: Copy of approval letter from OT Advisory Committee.
- (G) Specialty Certification. Achievement of a specialty certification by a recognized body such as Neuro Developmental Techniques, Sensory Integration, American Society of Hand Therapists will be awarded 20 points one time only. Credit will be granted for Certification obtained within the compliance period in which certification was granted or the next subsequent compliance period only.
- (H) Professional Activities
- (4i) American Occupational Therapy Association membership: 2 points Documentation: Copy of current AOTA membership card.
 - (2ii) Oklahoma Occupational Therapy Association or American Occupational Therapy Association elected office (up to 8 points per year). Documentation: Copy of annual report submitted to OOTA or AOTA listing activities of office.
 - (3iii) AOTA or OOTA Committee chair - points awarded based on the extent to which activities are relative to maintaining involvement in the profession as evidenced by their annual report (up to 8 points per year). Documentation: Copy of approval letter from OT Advisory Committee.
 - (4iv) Member of Committee - based on evidence of involvement in appropriate activities (up to 4

points per year). Documentation: Copy of approval letter from OT Advisory Committee.

(5v) Active involvement in related organizations and committee upon approval by the Committee (up to 4 points per year). Documentation: List of dates of activities and types of activities, signed by committee chair, with a statement of relevance of the organization or committee to the practice of occupational therapy.

(c) **Renewal license identification card.** The Board shall issue to a licensee who has met all requirements for renewal a renewal license identification card.

(d) **Re-entry guidelines.** Therapists with licenses lapsed more than twelve months wishing to re-enter the practice of Occupational Therapy will be required to file an application on forms provided by the Board. Therapists may be required to meet one or more of the following guidelines:

- (1) Personal appearance before the Advisory Committee.
- (2) At least 2 Continuing Education Units for each month license was lapsed.
- (3) Practice under the direct supervision of a licensed Occupational Therapist for one month (at least 22 days) for each year license was lapsed up to three months. The supervising Therapist will provide to the Committee a report on the applicant's performance prior to licensure.
- (4) ~~A.O.T.C.B. licensure~~ NBCOT certification examination.

(e) **Personal appearance requirement.** Therapists with licenses lapsed more than sixty months wishing to re-enter practice will be required to make a personal appearance before the Committee and meet any of the above guidelines as directed by the Committee.

[OAR Docket #07-614; filed 4-2-07]

**TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
CHAPTER 45. RESPIRATORY CARE PRACTITIONER**

[OAR Docket #07-615]

RULEMAKING ACTION:

PERMANENT final adoption.

RULES:

Subchapter 5. Regulation of Practice
435:45-5-1. Continuing education [AMENDED]

AUTHORITY:

Title 59 O.S., Section 2031, Board of Medical Licensure and Supervision

DATES:

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November 7, 2006

Gubernatorial approval:

December 21, 2006

Legislative approval:

Failure of the Legislature to disapprove the rule resulted in approval on March 27, 2007.

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March 27, 2007

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May 11, 2007

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 5. Regulation of Practice
435:45-5-1. Continuing education [AMENDED]

Gubernatorial approval:

March 16, 2006

Register publication:

23 Ok Reg 822

Docket number:

06-388

INCORPORATED BY REFERENCE:

n/a

ANALYSIS:

The rule regarding continuing education was amended to require at least half of the hours to be directly related to clinical practice and approve resuscitation and life support courses.

CONTACT PERSON:

Jan Ewing, Deputy Director, 405-848-6841, #104

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 5. REGULATION OF PRACTICE

435:45-5-1. Continuing education

(a) The purpose of continuing education is to aid in maintaining competency in the advancing art and science of respiratory care. Continuing education is a variety of forms of learning experiences including, but not limited to, lectures, conferences, academic studies, in-services education, institutes, seminars, home study, Internet courses, and workshops taken by Respiratory Care Practitioners for licensure renewal. These learning experiences are meant to enhance the knowledge of the Respiratory Care Practitioner in direct and indirect patient care. Continuing education does not include basic education or training needed to become a licensed RCP.

(b) All program objectives, curricular content, presenter qualifications, and outcomes shall be subject to review. Contact hours will be determined based on program content, outcomes, and participant involvement.

(~~a~~c) Respiratory Care Practitioner licenses shall be renewed every two years on or before the last day of the month in which initial licensure was granted. The application and fee for renewal of licensure shall be postmarked or hand delivered to the Board office on or before the required date.

(~~b~~d) Regardless of the source, continuing education hours must be in clinical respiratory care or related areas of health care. The Board may consult with the Committee to resolve questions as to appropriate continuing education hours. The Board of Medical Licensure and Supervision shall be the final

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authority on acceptance of any educational activity requirements submitted by a licensee to meet the continuing education requirements.

(e) Licensees shall be responsible for submitting documentation of their continuing education unit activities to the Board at the time of license renewal.

(f) Respiratory Care Practitioners must accrue twelve (12) CRCE (Continuing Respiratory Care Education) credits in each successive two year period (biennium) to maintain a license to practice in the state of Oklahoma. At least half of the required Continuing Respiratory Care Education hours must be directly related to clinical practice. Unless otherwise specified, one clock hour of direct instruction/training class time is equivalent to one continuing education unit.

(g) The Board shall accept American Medical Association (AMA) and America Osteopathic Association (AOA) credits. Other acceptable continuing education credits include all programs approved by, or where applicable the affiliates of, the American Association for Respiratory Care (AARC); the American Thoracic Society (ATS); the American College of Chest Physicians (ACCP); the American Society of Anesthesiology (ASA); the American Lung Association (ALA); the American College of Cardiology (ACC); the American Heart Association (AHA); the American Nursing Association (ANA), American Red Cross and the American Council for Continuing Medical Education (ACCME).

(h) Other agencies and professional organizations may be considered and approved for eligible continuing education credits upon review by the Chairman of the Committee with final approval by the Secretary of the Board. Those wishing to sponsor a program/meeting/class and receive approval for awarding CRCE credits must contact the Board and receive approval in advance. To apply toward satisfaction of the continuing education requirements, the following shall be submitted:

(1) The request shall be submitted in writing to the Board office at least thirty (30) days prior to the program. The Board shall give written notification of the approval or disapproval of the educational program or seminar.

(2) A request to be an eligible continuing education seminar or course shall include:

- (A) Name of the seminar or course;
- (B) Sponsoring party;
- (C) Objective of the seminar or format and subjects of seminar or course;
- (D) Number of hours resulting in CRCEs;
- (E) Method for certification of attendance;
- (F) Name and qualifications of the faculty; and
- (G) Evaluation mechanism.

(i) RCPs who submit proof of successful completion of the National Board for Respiratory Care (NBRC) entry or the advanced practitioner credentialing examination or recertification examination may be granted continuing education credit as awarded by the American Association for Respiratory Care.

(j) Credits may be awarded for completion of continuing education processes in accordance with the following guidelines:

(1) Direct conference/lecture/classroom attendance - 1.0 CRCE per hour.

(2) Teleconference (audio only) - 0.5 CRCE per hour.

(3) Teleconference (audio with handouts or slides) - 1.0 CRCE per hour.

(4) Videoconference (live video) - 1.0 CRCE per hour.

(5) Video tape instruction/programs - 0.2 CRCE per hour.

(6) Correspondence journal/workbooks with test - 0.2 CRCE per subject.

(7) Interactive video instruction (computer) with test - 1.0 CRCE per subject.

(8) NBRC recertifying examination (passing) - 6.0 CRCE per biennium.

(9) Resuscitation and life support courses - limit one of the following courses per compliance period:

(A) Advanced Cardiac Life Support - 6 CRCE;

(B) Neonatal Resuscitation Program - 6 CRCE;

(C) Pediatric Advanced Life Support - 6 CRCE;

(D) Advanced Trauma Life Support - 6 CRCE;

(E) Basic Life Support - 6 for initial certification; 3 for recertification.

[OAR Docket #07-615; filed 4-2-07]

TITLE 465. OKLAHOMA MOTOR VEHICLE COMMISSION CHAPTER 10. LICENSE

[OAR Docket #07-684]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. License Identification and Changes

465:10-3-2 [AMENDED]

465:10-3-3 [AMENDED]

Subchapter 7. Off Premise Sale and Display

465:10-7-1 [AMENDED]

465:10-7-2 [AMENDED]

465:10-7-3 [AMENDED]

Subchapter 9. Dealership Locations

465:10-9-1 [AMENDED]

465:10-9-2 [AMENDED]

AUTHORITY:

Oklahoma Motor Vehicle Commission, Title 47, Sections 563(F), 564, 564.1, 565, and Title 75, Section 302(A)(2)

DATES:

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No public hearing was scheduled. No request for public hearing was received.

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SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The amendments for Subchapter 3 update obsolete requirements and clarify the procedures for issuance of dealer and salesperson licenses. The proposed changes for Subchapter 7 better define the differences between an off premise display and sale, while altering the notice and permit regulations. The proposed amendments for Subchapter 9 update dealership facility requirements.

CONTACT PERSON:

Marilyn Maxwell, Deputy Director, Oklahoma Motor Vehicle Commission, 4334 N.W. Expressway, Suite 183, Oklahoma City, OK 73116, (405) 607-8227, ext 101

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 3. LICENSE IDENTIFICATION AND CHANGES

465:10-3-2. Name to be placed on dealer's license

Dealer licenses will be issued in the ~~name of the corporation, partnership or the~~ trade name of the proprietor applicant, ~~when the applicant has submitted a complete roster of salespersons in his or her employ~~ and said license licenses shall be displayed in a conspicuous location at the Dealer's place of business.

465:10-3-3. Salespersons' license

(a) **License.** ~~At the same time and contemporaneous~~ Contemporaneous with a new Salesperson being employed, an application for Salesperson License shall be submitted to the Commission on forms prescribed by the Commission along with the appropriate fee. A license for a Motor Vehicle Salesperson will not be issued, renewed, or endorsed until the employing Dealer is licensed and has certified that the applicant for said license is in his or her employ. It is not intended that the Dealer pay for licenses for its Salespersons. However, for convenience, the Dealer may do so on a reimbursable basis or any other plan satisfactory to its organization. All Salesperson licenses will be sent to the Dealer for distribution to his or her respective applicants, and the Dealer will determine that all its personnel required to obtain license have done so. Salesperson Licenses are required for anyone involved in the selling of new or used vehicles, including sales managers and F&I personnel.

(b) **Identification card.** A Salesperson's license shall consist of an identification card. The card shall be carried upon his or her person when acting as a Salesperson.

(c) **Termination of employment.** Upon termination of employment of a licensed Salesperson, the dealership must notify the Motor Vehicle Commission in writing within ten days.

(d) **One license and employer at a time.** No Salesperson may hold more than one license at any one time or be employed by, or sell for, any Dealer other than the Dealer designated on the Salesperson's license.

(e) **Change of employment.** A licensed Salesperson shall, on change of employment, ~~submit~~ surrender his or her the Salesperson's License Certificate to ~~his or her the new employer for submission~~ employer, who shall submit the license along with the appropriate transfer form to the Commission for endorsement reflecting the change of employers.

SUBCHAPTER 7. OFF PREMISE SALE AND DISPLAY

465:10-7-1. Purpose

The rules in this subchapter provide additional off premise sale and display requirements. ~~and further outlines the granting of "Variances" to the mileage limitations set forth in Title 47 O.S. Supp. 1985, Section 564.1.~~

465:10-7-2. Receipt of applications

All applications for Off Premise Display or Sales Licenses issued pursuant to 47 O.S. Supp. ~~1985 2005~~, Section 564.1 (as amended), shall be submitted on forms to be furnished by the Commission and must be received by the Commission at least ~~twenty (20)~~ seven (7) calendar days prior to the date of the off premise sale or display.

465:10-7-3. Off premise display events

(a) ~~No sales activities.~~ Off premise display events. No sales activities shall be conducted at an off premise display, including but not limited to, negotiations, financing, and accepting credit applications. The presence of sales or finance personnel at an off premise display, creates a rebuttable presumption that sales activities are being conducted at the off premise display event.

(b) **Off premise sales events.** Sales activities may be conducted by recreational vehicle dealers at a licensed off premise sale.

(c) **License affixed to windshield.** An ~~Off Premise Display License off premise display or sale license~~ issued by the Commission pursuant to 47 O.S. Supp. ~~1985 2005~~, Section ~~564.1(1) 564.1~~ (as amended), shall be prominently affixed to the windshield of each new motor vehicle. ~~displayed and shall conspicuously state "This Vehicle For Display Only, Not For Sale".~~

SUBCHAPTER 9. DEALERSHIP LOCATIONS

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465:10-9-1. Purpose

The rules of this subchapter provide definition of established business locations and restrict usage of "line-make" identification of ~~vehicles in the trade name~~ at locations other than the primary franchised licensed location.

465:10-9-2. Definition of established place of business

An established place of business as used in 47 O.S. Supp., 2001, Section 565 (7)(a), (as amended), shall mean a permanently enclosed building or ~~structure~~ structure, ~~either owned in fee or leased~~, easily accessible to the public, with a paved or graveled lot for customer parking and for the showing and storage of vehicles, ~~and at which place of business shall be kept and maintained the books, records and files necessary to conduct said business;~~ and, shall not mean residences, tents, temporary stands, lots, or other temporary quarters. ~~An~~ The established place of business must have a sign visible from the outside which identifies the motor vehicle dealership. An established place of business shall also include a an indoor show room capable of housing displaying at least one vehicle with entrance/exit doors large enough to accommodate a vehicle, provided, however, the Commission may waive this requirement to persons dealerships engaged in the business of selling medium or heavy duty trucks or motor home recreational vehicles only. It shall also include a service department large enough to handle expected service needs, warranty work, with at least one lift and an exhaust system for insuring customers' and employees' safety; a parts department large enough to house a sufficient number of parts and must have a counter for retail customers separate from the service entrance; and adequate restroom facilities for men and women. It shall also have indoor office and public areas sufficient to conduct sales transactions with customers, and have restroom facilities available for the public. The established place of business shall also include a service and parts area, separated from the public areas, equipped with tools, equipment, and replacement parts necessary for reasonably expected warranty and service needs, and equipped with the means to vent exhaust directly from vehicles being repaired to the outside. This definition is intended to clarify and supplement the language in 47 O.S. Supp. ~~1985~~, 2001, Section 565 ~~(7)(b)-"~~ (7)(b), (as amended).

[OAR Docket #07-684; filed 4-4-07]

TITLE 465. OKLAHOMA MOTOR VEHICLE COMMISSION CHAPTER 15. ADVERTISING

[OAR Docket #07-685]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions
465:15-1-2 [AMENDED]
Subchapter 3. Specific Advertising Regulations
465:15-3-7 [AMENDED]
465:15-3-14 [AMENDED]
Subchapter 7. Enforcement

465:15-7-2 [AMENDED]

AUTHORITY:

Oklahoma Motor Vehicle Commission, Title 47, Sections 563(F), 564.1, and Title 75, Section 302(A)(2)

DATES:

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SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed rule amendments would modify the current advertising regulations under the headings of Definitions, Dealer Price Advertising, Prohibited Statements and Enforcement. These amendments would update and provide clarity to the rules in response to the ever changing styles and trends of advertising by new motor vehicle dealers. The intended effect of the proposed amendments will assist the Commission with proper enforcement to protect the citizens of Oklahoma from false and misleading advertising and ensure fair treatment for all dealers.

CONTACT PERSON:

Marilyn Maxwell, Deputy Director, Oklahoma Motor Vehicle Commission, 4334 N.W. Expressway, Suite 183, Oklahoma City, OK 73116, (405) 607-8227, ext 101

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

465:15-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"**Advertisement**" means an oral, written, graphic or pictorial statement made in the course of soliciting business, including, without limitation, a statement or representation ~~made contained~~ made contained in a newspaper, magazine, ~~or other publication, or contained in a notice, sign, poster, display, circular, pamphlet, or letter, or on the Internet, radio or on radio, television, television, or any other type of media.~~

"**Bait advertisement**" means an alluring but insincere offer to sell a product of which the primary purpose is to obtain

leads to persons interested in buying merchandise of the type advertised and to switch consumers from buying the advertised product in order to sell some other product at a higher price or on a basis more advantageous to the advertiser.

"Clear and Conspicuous" means that the statement, representation, or disclosure is of such size, color, contrast, and audibility and is presented so as to be readily noticed and understood. All language and terms, including abbreviations, shall be used in accordance with their common or ordinary usage and meaning. This standard shall be met by the following:

- (A) In a print advertisement:
 - (i) The type size of 5 1/2 caps or larger shall be used in all disclosures.
 - (ii) Disclosures shall be located adjacent to the price or in an area clearly marked with reference symbols. All reference symbol marks, such as asterisks, must be type size 5 1/2 caps or larger.
- (B) In an audio advertisement:
 - (i) The disclosure shall be clear and understandable in pace and volume; and,
 - (ii) The disclosure shall be placed at the end of the advertisement.
- (C) In a television advertisement:
 - (i) The disclosure shall be in visual form so that the average viewer can easily read and understand it.
 - (ii) The disclosure size shall be at least twenty (20) scan lines and each disclosure shall appear continuously on the screen at least ten (10) seconds.

"Dealership addendum" means a form which is to be displayed on a window of a new motor vehicle when the dealer installs special features, equipment, parts or accessories, or charges for services required to prepare a vehicle for delivery to a buyer. The addendum is to disclose:

- (A) That it is supplemental and it should not be deceptively similar in appearance to the manufacturer's label, which is required to be affixed by every manufacturer to the windshield or side window of each new motor vehicle under the Automobile Information Disclosure Act;
- (B) Any added feature, service, equipment, part, or accessory charged and added by the dealership and the retail price thereof;
- (C) Any additional charge to the selling price such as additional dealership markup; and,
- (D) The total dealer selling price

"Demonstrator" means those vehicles that are of the current or previous model year which have not been sold, titled or registered to any type of purchaser and are used by dealership personnel for demonstration purposes. Service vehicles, courtesy cars, daily rentals, loaners, driver education and factory executive cars shall not be described as "demonstrator" vehicles. Demonstrators may be advertised for sale, as such, only by a franchised dealer of the same line-make of vehicle.

"Disclosure" means required information that is clear, conspicuous, and accurate.

"Factory executive/official vehicle" means a new motor vehicle with an original Manufacturer's Statement of Origin, that has been used exclusively by an executive or official of the dealer's franchising manufacturer, distributor, or their subsidiaries.

"Licensee" means any entity or person required to obtain a license from the Oklahoma Motor Vehicle Commission.

"Manufacturer's label" means the label required by the Automobile Information Disclosure Act, 15 U.S.C. Sections 1231-1233, (normally referred to as Monroney Label), to be affixed by the manufacturer to the windshield or side window of each new automobile delivered to a dealer.

"Program car" means a car that is purchased at a manufacturer's closed auction or sold by or directly from the manufacturer or distributor which is a current or previous year model, that has been previously tagged and/or titled, and returned to the manufacturer for disposal.

"Rebate" or "Cash back" means a sum of money refunded to a purchaser or for the benefit of the purchaser. The purchaser may choose to reduce the amount of the purchase price by the sum of money or the purchaser may opt for the money to be returned to the purchaser for his or her benefit.

465:15-3-7. Dealer price advertising

(a) **Selling price.** The most conspicuous price of a new motor vehicle, when advertised by a dealer, must be the full and total selling price for which the dealer will sell the ~~vehicle.~~ vehicle to any retail buyer. The only charges that may be excluded from the advertised price are:

- (1) state and local taxes,
- (2) license, and
- (3) title.

(b) **Qualification.** A qualification may not be used when advertising the price of a vehicle such as "with trade", "with acceptable trade", "with dealer-arranged financing", or "with down payment".

(c) **Rebate or savings incentive claim.** ~~If a price advertisement discloses a rebate, cash back, discount savings claim, or other incentive, the full cash price of the vehicle must be disclosed as well as the price of the vehicle after deducting the incentive.~~ If an advertised price includes any rebates, cash back, or other incentives, the ad must clearly disclose that the price includes the rebate or incentive.

(d) **Rebates only available to select consumers.** The most conspicuous price or payment of a new motor vehicle, when advertised by a dealer, must be the true price that is available for every consumer. Rebates that are only available to select consumers shall ~~not be deducted from the price or payment, but must be presented as an additional actual savings to this select group.~~ either be presented as additional savings to the select group, or presented as separate prices or payments which clearly identify to whom the price or payment applies.

465:15-3-14. Prohibited statements

The following statements are presumptively false and misleading, and the burden of proving otherwise shall be on the Advertiser/Licensee:

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- (1) Statements such as "everybody financed", "no credit rejected", "guaranteed approval", "you are pre-approved", and other similar statements representing or implying that no prospective credit purchaser will be rejected because of his inability to qualify for credit.
- (2) Statements representing that no other dealer grants greater allowances for trade-ins, however stated, unless such is the case.
- (3) Statements representing that because of its large sales volume a dealer is able to purchase vehicles for less than another dealer selling the same make of vehicles, unless such is the case.
- (4) Statements such as "factory direct prices", "whole-sale prices", "factory sale", and other similar statements that create the impression that the vehicle is being offered for sale by the manufacturer or distributor of the vehicle, are prohibited. Dealers may use terms such as "factory authorized sale" only in conjunction with factory-sponsored promotions and/or advertising campaigns. Statements such as "we have been selected", "we have been chosen", and other similar statements, which imply that the dealership has exclusive arrangements not available to other dealers, are prohibited.
- (5) A savings claim or discount offer is prohibited except to advertise a specific new or demonstrator ~~vehicle.~~ vehicles. Statements such as "up to", "as much as", "from", shall not be used in connection with savings or discount ~~claims.~~ claims, unless the vehicle for which the claim is made is clearly identified including the stock number. Savings claims can only be offered from the bottom line MSRP sticker price. Discounts shown on the Monroney Sticker Label shall not be included in the advertised discount or savings claim. The featured savings claim or discount offer for a new motor vehicle, when advertised, must be the savings claim or discount which is available to any and all members of the buying public.
- (6) The use of the ~~term~~ "Free" terms "Free", "Complimentary", or similar terminology is prohibited if a consumer must make a purchase to obtain the "free" offer.
- (7) The terms "dealer's cost", "invoice", "invoice price" or other reference to the cost of the vehicle to the dealer shall not be used.
- (8) No trade-in amount or range of amounts shall be advertised.
- (9) A used vehicle shall not be advertised in any manner that creates the impression it is new.
- (10) Statements such as "we pay tag, tax and ~~license~~", "license" ~~"we buy tag, tax and license", "we pay tag, title and tax"~~ or statements with similar meaning shall not be used.
- (11) The use of the terms "liquidation", "going out of business", or statements with similar meaning, are prohibited unless a dealer is actually going out of business and ceasing its operations at the licensed location. If a dealer is going out of business, these terms can only be advertised during the period between the execution of a buy-sell with the proposed buyer and written factory approval.

- (12) An offer of a buy down rate is prohibited without the appropriate disclaimer: "This is a buy down rate. The amount of the buy down may affect the price of the vehicle".
- (13) Terminology such as "we will pay off your trade no matter how much you owe" or statements with similar meaning shall not be used, unless accompanied by a disclaimer indicating that pay off amount is added into the contract and is dependent upon approved credit.

SUBCHAPTER 7. ENFORCEMENT

465:15-7-2. Enforcement procedures

(a) Finding. Upon a finding that an advertisement is in violation of the advertising regulations, referenced in Subchapter 3, the Commission shall apply the following procedures:

- (1) **Violation.** Any violation for unlawful advertising for each dealership location will result in a letter advising the dealer of the violation.
 - (2) **Second violation.** A second violation within the last six months will result in a letter, sent by certified mail, advising the dealer of the infraction and warning that a third violation within the last six months could require the dealer to appear before a hearing by the Commission to determine the possibility of an imposition of a fine and/or suspension or revocation of the dealer's license.
 - (3) **Third violation.** A third violation within the last six months will result in a letter, sent by certified mail, advising the dealer of dealer's hearing date to determine the possibility of an imposition of a fine and/or suspension or revocation of the dealer's license. A dealer may offer to pay a fine of \$250.00 in lieu of a hearing. The Commission may, at its discretion, accept the fine or schedule a hearing at the next regularly scheduled meeting.
 - (4) **Fourth violation.** A fourth violation within the last six months will result in a letter sent by certified mail advising the dealer of dealer's hearing date to determine the possibility of an imposition of a fine and/or suspension or revocation of the dealer's license. A dealer may offer to pay a fine of \$500.00 in lieu of a hearing. The Commission may, at its discretion, accept the fine or schedule a hearing at the next regularly scheduled meeting.
 - (5) **Fifth violation.** A fifth violation within the last six months will automatically result in a notice of hearing sent by certified mail. The dealer may not offer to pay a fine in lieu of a hearing.
- (b) **Correspondence.** All certified letters should be addressed to ~~"ADDRESSEE ONLY" Dealer Principal/Operator, Majority Owner/Stockholder or Executive Manager the Licensee~~ with "RETURN RECEIPT REQUESTED".

[OAR Docket #07-685; filed 4-4-07]

**TITLE 530. OFFICE OF PERSONNEL
MANAGEMENT
CHAPTER 10. MERIT SYSTEM OF
PERSONNEL ADMINISTRATION RULES**

[OAR Docket #07-656]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions
Part 1. General Provisions
530:10-1-2 [AMENDED]
Part 3. Delegation of Human Resource Functions
530:10-1-43 [AMENDED]
Subchapter 3. Affirmative Action and Equal Employment Opportunity
Part 3. Affirmative Action
530:10-3-33.6 [AMENDED]
530:10-3-33.7 [AMENDED]
Part 5. Noncompliance, Investigations, Hearings, and Remedies
530:10-3-54 [AMENDED]
Subchapter 7. Salary and Payroll
Part 1. Salary and Rates of Pay
530:10-7-1 [AMENDED]
530:10-7-6 [AMENDED]
530:10-7-7 [AMENDED]
530:10-7-11 [AMENDED]
530:10-7-12 [AMENDED]
530:10-7-14 [AMENDED]
530:10-7-17 [AMENDED]
Subchapter 9. Recruitment and Selection
Part 1. General Provisions
530:10-9-4 [AMENDED]
530:10-9-5 [AMENDED]
Part 3. Written and Performance Tests
530:10-9-37 [AMENDED]
530:10-9-38 [AMENDED]
530:10-9-39 [AMENDED]
530:10-9-40 [AMENDED]
Part 5. Registers
530:10-9-51 [AMENDED]
530:10-9-52 [AMENDED]
530:10-9-54 [AMENDED]
Part 7. Certification
530:10-9-76 [AMENDED]
Part 9. Classified Appointments
530:10-9-99 [AMENDED]
530:10-9-100 [AMENDED]
Part 13. Veterans Preference
530:10-9-130 [AMENDED]
Subchapter 11. Employee Actions
Part 1. General Provisions
530:10-11-1 [AMENDED]
Part 3. Probationary Employees
530:10-11-31 [AMENDED]
530:10-11-32 [AMENDED]
530:10-11-39 [AMENDED]
Part 7. Transfers and Voluntary Demotions
530:10-11-71 [AMENDED]
Subchapter 13. Reduction-in-Force
Part 1. General Provisions for Reduction-in-Force
530:10-13-1 [AMENDED]
530:10-13-2 [AMENDED]
530:10-13-3 [AMENDED]
Part 3. Reduction-in-Force Plan Requirements
530:10-13-32 [AMENDED]
Subchapter 15. Time and Leave
Part 1. General Provisions
530:10-15-1 [AMENDED]
Part 3. Annual and Sick Leave Policies
530:10-15-10 [AMENDED]
530:10-15-12 [AMENDED]

Part 5. Miscellaneous Types of Leave
530:10-15-45 [AMENDED]
530:10-15-49 [AMENDED]
Subchapter 17. Performance Evaluation and Career Enhancement Programs
Part 7. Carl Albert Public Internship Program
530:10-17-74 [AMENDED]
530:10-17-75 [AMENDED]
530:10-17-77 [AMENDED]
530:10-17-80 [AMENDED]
Part 11. Certified Public Manager Program
530:10-17-110 [AMENDED]
530:10-17-111 [AMENDED]
530:10-17-115 [AMENDED]

AUTHORITY:

The Administrator of the Office of Personnel Management: 74 O.S., §§ 840-1.6A, 840-2.1, 840.2.10, 840-2.17, 840-2.20, 840-2.22, 840-2.27C, 840-2.29, 840-3.5, 840-3.8, 840-4.11, 840-4.12, 840-4.13, 840-4.14, 840-4.17, and 4121.

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Failure of the Legislature to disapprove the rules resulted in approval on March 28, 2007

Final adoption:

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Effective:

May 11, 2007

SUPERSEDED EMERGENCY ACTIONS:

None.

INCORPORATIONS BY REFERENCE:

None.

ANALYSIS:

The proposed amendments to 530:10-3-33.6 are to delete references to the Oklahoma Employment Security Commission's "Labor Force Information Affirmative Action Programs," and allow the Administrator of the Office of Personnel Management to specify which civilian labor force information is to be used. The proposed amendments to 530:10-3-33.7, are to clarify the process for utilization analysis of affirmative action plans. The proposed amendment to 530:10-7-12 is to clarify and make consistent compensatory time accrual guidelines between FLSA exempt and non-exempt employees. The proposed amendment to 530:10-7-14 is to clarify that an employer may set an employee's salary upon intra-agency lateral transfer at more than 5% of the employee's salary before transfer if it is within the hiring range. The proposed amendments to 530:10-9-4, 530:10-9-5, 530:10-9-37, 530:10-9-38, 530:10-9-39, 530:10-9-40, 530:10-9-51, 530:10-9-52, 530:10-9-54, and 530:10-9-76 are to reflect changes to the application process as a result of new software and to provide flexibility for future software upgrades. The proposed amendment to 530:10-9-100 is to rename the Persons with Severe Disabilities Employment Program and streamline the application process for certified applicants. The proposed amendment to 530:10-9-130 is to clarify the definition of veteran for hiring purposes. The proposed amendment to 530:10-11-71 describes action that may be taken if an employee does not prove satisfactory during the trial period on an intra-agency lateral transfer. The proposed amendments to 530:10-13-2 harmonizes the definitions with those in the Oklahoma Personnel Act. The proposed amendment to 530:10-13-32 conforms the rule to statute as to the order of removal during a reduction-in-force and preference for veterans. The proposed amendment to 530:10-15-45 implements statutory change allowing for FMLA leave to be paid with accrued compensatory time. The proposed amendment to 530:10-15-49 clarifies that the section applies to all employees. The proposed

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amendment to 530:10-17-115 is to clarify the process for assessment and payment of program fees by removing contradictory language.

All other amendments not specifically mentioned are to correct or add citations to permanent rules.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

PART 1. GENERAL PROVISIONS

530:10-1-2. Definitions

In addition to terms defined in OAC 455:10-1-2, the following words and terms, when used in the Merit Rules, shall have the following meaning, unless the context clearly indicates otherwise.

"Absence without leave" and **"unauthorized absence"** means any absence of an employee from duty without specific approval.

"Absolute preference veteran" means a veteran eligible for placement at the top of registers for appointment to the classified service because of a service-connected disability of 30% or more.

"Act" means the Oklahoma Personnel Act.

"Administrator" means the appointing authority of the Oklahoma Office of Personnel Management [74:840-1.3]. As the term is used in the Merit Rules, the term includes employees of the Office of Personnel Management to whom the Administrator has lawfully delegated authority to act on his or her behalf. The term, as used in the Merit rules, may also include Appointing Authorities to whom the Administrator has delegated authority under a duly executed delegation agreement.

"Adverse impact" or **"disparate impact"** means a substantially different rate of selection in hiring, promotion, or other employment decision which works to the disadvantage of members of a race, sex, or ethnic group. A common yardstick for determining adverse impact is the **"4/5ths rule"** which indicates adverse impact if the selection rate for any protected group is less than 4/5ths (80%) of the selection rate of the group with the highest selection rate.

"Agency" means any office, department, board, commission or institution of the executive branch of state government [74:840-1.3].

"Allocation" or **"Position allocation"** means the process by which the Office of Personnel Management designates a position to an established job family. A position is allocated on the basis of duties, authority, responsibilities, classification guides, and other appropriate factors.

"Appointing authority" means the chief administrative officer of an agency [74:840-1.3]. As the term is used in the Merit Rules, the term includes employees of an agency to whom the Appointing Authority has lawfully delegated authority to act on his or her behalf.

"Assignment" or **"Position assignment"** in the context of position allocation means the process by which an Appointing Authority designates a position to an established job family level.

"Balanced and representative work force" means a work force whose composition at all levels approximates the composition of the relevant civilian labor force in terms of race, sex, and ethnicity.

"Base pay", **"base rate"**, or **"base salary"** means the hourly rate or salary established for a job performed. It does not include shift differentials, benefits, overtime, incentives, longevity, or any other pay elements.

"Break in service" means a period of time in excess of thirty (30) days during which an employee is not present at work and is not in paid leave status or on approved leave without pay.

"Career progression" means a type of intra-agency promotion in which an employee is advanced from one level of a job family to a higher non-supervisory level in the same job family.

"Certification", in the context of initial classified appointments, means the submission of available names of eligibles from the appropriate register to an Appointing Authority. Such a list is called a **"certificate"**. Individuals whose names appear on the certificate are said to be **"certified"**. In the context of all other types of appointments, certification means the determination by the Office, or by an Appointing Authority to whom the Administrator has delegated authority, that a candidate possesses permanent classified status or is eligible for reinstatement to permanent classified status, and meets requirements for appointment to a specified job in the classified service.

"Classification" means:

(A) the process of placing an employee into an appropriate job family and level within the job family, consistent with the allocation of the position to which the employee is assigned, or

(B) an employee's job family and the level at which work is assigned [74:840-1.3].

"Classification plan" means the orderly arrangement of positions within an agency into separate and distinct job families so that each job family will contain those positions which involve similar or comparable skills, duties and responsibilities [74:840-1.3].

"Classified employee" means an employee in the classified service, or an employee currently on leave from the classified service in accordance with established Merit Rules governing leave.

"Classified service" means state employees and positions under the jurisdiction of the Oklahoma Merit System of Personnel Administration [74: 840-1.3].

"Commission" means the Oklahoma Merit Protection Commission [74:840-1.3].

"Compensation plan" means a schedule of salaries or hourly wages established for the jobs recognized in the agency classification plan so that all positions of a given job within an agency may be paid the same salary range established for the job.

"Consider" means a reasonable judgment based on job related criteria and on an individual's fitness for duties for initial or internal appointment.

"Demotion" means the reclassification of a classified employee to a different job with a lower pay band assignment or to a lower level within the same job family. Demotion may be voluntary or involuntary.

"Direct reclassification" means a change made in a classified employee's classification by an Appointing Authority as a result of the adoption of a new or revised job family descriptor.

"Discharge" is defined in 455:10-11-3.

"Displacement" or **"displace"** means the process of an employee accepting an offer of employment to an occupied or funded vacant position [74:840-2.27B].

"EEO Job Categories", as used in the context of affirmative action/equal employment opportunity, means the following occupational categories:

(A) **Officials and Administrators:** Occupations in which employees set broad policies, exercise overall responsibility for execution of these policies, or direct individual departments or special phases of the agency's operations, or provide specialized consultation on a regional, district, or area basis.

(B) **Professionals:** Occupations which require specialized and theoretical knowledge which is usually acquired through college training or through work experience and other training which provides comparable knowledge.

(C) **Technicians:** Occupations which require a combination of basic scientific or technical knowledge and manual skill which can be obtained through specialized post-secondary school education or through equivalent on-the-job training.

(D) **Protective Service Workers:** Occupations in which workers are entrusted with public safety, security and protection from destructive forces.

(E) **Paraprofessionals:** Occupations in which workers perform some of the duties of a professional or technician in a supportive role, which usually require less formal training and/or experience normally required for professional or technical status.

(F) **Administrative Support (Including Clerical and Sales):** Occupations in which workers are responsible for internal and external communication, recording and retrieval of data and/or information and other paperwork required in an office.

(G) **Skilled Craft Workers:** Occupations in which workers perform jobs which require special manual skill and a thorough and comprehensive knowledge of the processes involved in the work which is acquired through on-the-job training and experience or through apprenticeship or other formal training programs.

(H) **Service-Maintenance:** Occupations in which workers perform duties which result in or contribute to the comfort, convenience, hygiene or safety of the general public or which contribute to the upkeep and care of buildings, facilities or grounds of public property.

"Eligible" means a person who has met all requirements for appointment to a given job.

"Employee" or **"state employee"** means an elected or appointed officer or employee of an agency unless otherwise indicated [74:840-1.3].

"Entrance examination" means any employment test used by the Office of Personnel Management to rank the names of applicants who possess the minimum requirements of education, experience, or licensure for a job or group of similar jobs on a register of eligibles established by the Office of Personnel Management [74:840-1.3].

"Executive Director" means the appointing authority of the Oklahoma Merit Protection Commission [74:840-1.3].

"FEPA" means the Oklahoma Fair Employment Practices Act, Section 840-4.12 of the Oklahoma Personnel Act.

"FLSA" means the federal Fair Labor Standards Act.

"FLSA exempt" means employees performing work which is considered to be exempt from the overtime payment provisions of the FLSA.

"FLSA non-exempt" means employees performing work which is considered to be under the overtime payment provisions of the FLSA.

"Hiring range" means a range within a pay band within which an Appointing Authority may establish the initial rate of pay for a given job.

"Hiring rate" means the initial rate of pay for a given job within the pay band assigned to the job family level.

"Hiring rule" refers to the names of the top 10 available eligibles certified to an Appointing Authority by the Administrator.

"Initial appointment" or **"original appointment"** means the act of an Appointing Authority hiring a person, usually from a certificate, for a probationary period. Contrast the meaning of these terms with "internal action" and "internal appointment" which are also defined in this Section.

"Interagency transfer" means an action in which an employee leaves employment with one agency and enters employment with another agency while continuously employed with the state [74:840-1.3].

"Internal action" or **"Internal appointment"** means the reclassification of a current employee or the reinstatement, recall or reemployment from a Priority Reemployment Consideration Roster of a former employee.

"Intra-agency transfer" means moving an employee from one position to another position with the same agency either with or without reclassification [74:840-1.3].

"Job" means a position or job family level in a job family [74:840-1.3].

"Job family" means:

(A) jobs which require similar core skills and involve similar work, and

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(B) *a logical progression of roles in a specific type of occupation in which the differences between roles are related to the depth and breadth of experience at various levels within the job family and which are sufficiently similar in duties and requirements of the work to warrant similar treatment as to title, typical functions, knowledge, skills and abilities required, and education and experience requirements* [74:840-1.3].

"Job family descriptor" means a written document that:

(A) *describes a job family, including, but not limited to, the basic purpose, typical functions performed, various levels within the job family, and the knowledge, skills, abilities, education, and experience required for each level, and*

(B) *identifies the pay band assigned for each level* [74:840-1.3].

"Job family level" or "level" means a role in a job family having distinguishable characteristics such as knowledge, skills, abilities, education, and experience [74:840-1.3].

"Job-related organization" means a membership association which collects annual dues, conducts annual meetings and provides job-related education for its members and which includes state employees, including any association for which payroll deductions for membership dues are authorized pursuant to paragraph 5 of subsection B of Section 7.10 of Title 62 of the Oklahoma Statutes [74:840-1.3].

"Lateral transfer" means the reassignment of an employee to another state job with the same pay band assignment as the job family level in which the employee was classified prior to the lateral transfer [74:840-1.3].

"Leave of absence without pay" means leave or time off from duty granted by the Appointing Authority, for which period the employee receives no pay.

"Manifest imbalance" means representation of females, Blacks, Hispanics, Asian/Pacific Islanders and American Indians/Alaskan natives in specific job groups or EEO job categories within the agency's work force that is substantially below its representation in the appropriate civilian labor force.

"Merit Rules" or "Merit Rules for Employment" or "Merit System of Personnel Administration Rules" means rules adopted by the Administrator of the Office of Personnel Management or the Oklahoma Merit Protection Commission pursuant to the Oklahoma Personnel Act [74:840-1.3]. Merit Rules adopted by the Administrator are in OAC 530:10, and Merit Rules adopted by the Commission are in OAC 455:10.

"Merit System" means the Oklahoma Merit System of Personnel Administration [74:840-1.3].

"Minimum qualifications" means the requirements of education, training, experience and other basic qualifications for a job.

"Minority" means a person who appears to belong, identify with, or is regarded in the community as belonging to one of the following racial or ethnic groups:

(A) **"Black"**, meaning all persons having origins in any of the Black racial groups of Africa;

(B) **"Hispanic"**, meaning all persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race;

(C) **"Asian or Pacific Islander"**, meaning all persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.

(D) **"American Indian or Alaskan Native"**, meaning all persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition. For affirmative action purposes, persons who are reported as American Indian shall verify tribal affiliation by providing a certificate of Degree of Indian Blood from the U.S. Department of Interior, Bureau of Indian Affairs, or by providing the name and address of tribal officials who can verify tribal affiliation [74:840-2.1].

"New position" means a position not previously existing.

"Noncompetitive appointment" means the appointment of a person to a noncompetitive job level within a job family [74:840-1.3].

"Noncompetitive job" means an unskilled or semiskilled job designated by the Office of Personnel Management as noncompetitive. Noncompetitive jobs do not require written examinations for placement on registers of eligibles [74:840-1.3].

"Office" means the Office of Personnel Management [74:840-1.3].

"Oklahoma Personnel Act" means Sections 840-1.1 et seq. of Title 74 of the Oklahoma Statutes, creating the Merit System of Personnel Administration and any amendments or supplements.

"Part-time employee" means an employee who works less than full time.

"Pay band" means the pay range assigned to a job family level.

"Payline" means the relationship between the rate of pay of a particular job family level and the assigned job evaluation points for the same job family level.

"Permanent employee" means a classified employee who has acquired permanent status in the classified service according to the Act and the Merit Rules.

"Position" means a group of specific duties, tasks and responsibilities assigned by the Appointing Authority to be performed by one person; a position may be part time or full time, temporary or permanent, occupied or vacant.

"Priority reemployment consideration" means the requirement that Appointing Authorities consider eligible former state employees who were separated as a result of a reduction-in-force whose names appear on Priority Reemployment Consideration Rosters before any vacant position is filled by any eligible initially appointed from an employment register.

"Probationary employee" means a classified employee who has not acquired permanent status in the classified service in accordance with the Act and the Merit Rules.

"Probationary period" means a working test period during which a classified employee is required to demonstrate fitness for the job to which appointed by the satisfactory performance of the duties and responsibilities of the job.

"Promotion" means the reclassification of a classified employee to a different job with a higher pay band assignment or to a higher level within the same job family.

"Promotional examination" means any employment test designated by the Office of Personnel Management to determine further the qualifications of a permanent classified employee of a state agency for employment in a different job for which the employee possesses the minimum qualifications of education, experience, or licensure within that agency [74:840-1.3].

"Reallocation" or **"Position reallocation"** means the process of reassigning an established position, occupied or vacant, from one job family to another.

"Recall right" means the entitlement of an eligible person to be offered reappointment to the job family level from which removed by a reduction-in-force before any other person may be appointed, except by recall.

"Reclassification" means the process of changing a classified employee from one job family to another job family or from one job family level to another job family level in the same job family, resulting in a change in the employee's assigned job code [74:840-1.3].

"Register" means a list of eligibles for original probationary appointment to a job.

"Register life" means the length of time during which a person's name may be continuously or intermittently on a register as a result of an entrance examination.

"Regular and consistent" means, in connection with an employee's work assignments, the employee's usual and normal work assignments, excluding incidental, casual, occasional tasks, and activities the employee assumes without direction to do so. Temporary work assignments of less than 60 days in any 12 month period are not considered regular and consistent.

"Regular unclassified service employee" means an unclassified service employee who is not on a temporary or other time-limited appointment [74:840-1.3].

"Reinstatement" means the reappointment of a former permanent classified employee as provided in the Merit Rules or the replacing of an eligible's name on a register.

"Resignation" means an employee's voluntary termination of his or her employment with the state. In the case of a classified employee, it includes the forfeiture of status in the classified service.

"Salary administration plan" means the plan adopted by an Appointing Authority and submitted to the Administrator for approval which establishes hiring ranges for positions. Components of a salary administration plan may include but are not limited to conditions for hiring above the midpoint of a pay range, skill-based pay programs, and other pay movement mechanisms authorized by Section 840-2.17 of the Oklahoma Personnel Act.

"Senior EEO Investigator" means a person who has been designated by the Administrator to provide advice and

support to persons completing the training requirements for discrimination complaints investigators as described in 530:10-3-22.

"Successor job family level" means a job family level that takes the place of another job family level.

"Supervisor" means a classified or unclassified employee [within the executive branch, excluding employees within The Oklahoma State System of Higher Education 74:840-3.1] who has been assigned authority and responsibility for evaluating the performance of [other state employees] [74:840-3.1][74:840-1.3].

"Trial period" means a working test period after promotion, voluntary demotion, or intra-agency lateral transfer during which a classified employee is required to demonstrate satisfactory performance in the job to which promoted, voluntarily demoted, or transferred before acquiring permanent status in the job.

"Unclassified service" or **"exempt service"** means employees and positions excluded from coverage of the Oklahoma Merit System of Personnel Administration [74:840-1.3]. Such employees and positions are subject to various provisions of the Oklahoma Personnel Act and the Merit Rules.

"Veteran" means a person who has been honorably discharged from the Armed Forces of the United States and who has been a resident of Oklahoma for at least 1 year before the date of examination [74:840-1.3].

PART 3. DELEGATION OF HUMAN RESOURCE FUNCTIONS

530:10-1-43. Written memorandum of agreement of delegated authority

(a) Before the Administrator approves the application for delegation authority, a memorandum of agreement shall be prepared by the Administrator in cooperation with the Appointing Authority. This delegation agreement shall include or incorporate by reference the following documents and information:

- (1) A description of the delegation authority;
- (2) An outline of the terms and conditions of the agreement, including an effective date for the agreement;
- (3) A description of audit activities, reports to the Administrator, and a description of records to be maintained by the Appointing Authority.
- (4) The application for delegation authorization, as amended before execution of the delegation agreement.
- (5) The list of delegation audit activities provided by the Administrator to the Appointing Authority.
- (6) The delegation standards, procedures, records, and reports required by the Administrator.
- (7) The timing of and methodology for conducting scheduled audits.
- (8) A statement describing the degree to which the personnel professional designated as the professional administrator of the delegated functions will act in the Appointing Authority's stead in regards to the delegated authority during the life of the agreement. The Appointing Authority shall not delegate ultimate responsibility for the

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agency's exercise of the delegated authority, or authority to sign or terminate the delegation agreement.

(b) The delegation agreement shall be dated and signed by the Appointing Authority of the requesting agency and then by the Administrator. The Administrator's signature on the agreement shall constitute approval of the application for delegation authority. Approval of this application for delegation authority shall constitute authority for the Appointing Authority or designee to implement the approved delegation of personnel authority. ~~[74:840-1.15(5)]~~[74:840-1.15] The Administrator shall send the Appointing Authority and the agency administrator of the delegated functions a copy of the agreement within five calendar days after signing the agreement.

SUBCHAPTER 3. AFFIRMATIVE ACTION AND EQUAL EMPLOYMENT OPPORTUNITY

PART 3. AFFIRMATIVE ACTION

530:10-3-33.6. Availability analysis

Affirmative action plans for agencies authorized **15** or more full-time-equivalent employees shall include an analysis of the number of minorities and females available to the workforce of the agency. An Appointing Authority shall:

- (1) Prepare an availability analysis for each job group;
- (2) Use the "~~Labor Force Information for Affirmative Action Programs~~" published by the ~~Oklahoma Employment Security Commission~~ civilian labor force information identified by the Administrator to obtain the raw availability percentage of minorities and females in the workforce, unless more appropriate data is available;
- (3) Consider all of the following availability factors and use at least one of the most appropriate considering how individuals are usually selected for employment within each job group:
 - (A) Percentage of minority population of the labor area surrounding the facility and the percentage of women seeking employment in the labor area surrounding the facility;
 - (B) Rate of minority or female unemployment in the surrounding labor area;
 - (C) Percentage of minorities or females in total work force in the immediate labor area;
 - (D) Availability of minorities or females with the requisite skills in the immediate labor area;
 - (E) Availability of minorities or females having requisite skills in the area which the agency can reasonably recruit;
 - (F) Percentage of minorities or females promotable and transferable within the agency's organization in the labor area. Unless a greater weight is approved by the Administrator, the weight for this factor shall not exceed **15%**;
 - (G) The existence of training institutions capable of training persons in the necessary skills;

(H) Estimate of training efforts the agency is reasonably able to undertake to make the job group available to minorities and females; and

(I) Other relevant factors if approved by the Administrator;

(4) Determine the appropriate geographic area for each factor used. This shall include the recruitment area from which most employees are drawn ~~and may vary between factors according to which table in the OESC State of Oklahoma Labor Force Information for Affirmative Action Programs is used;~~

(5) Weight each factor used. The weight shall represent the percentage of all employees in the job group who come from the source referenced in a particular factor, and the total of all factors used shall always equal **100%**; and

(6) Complete a form prescribed or approved by the Administrator to record availability analysis. The form shall provide spaces for availability information, including but not limited to: EEO job category and job group data, raw availability statistics, availability factors, weight factors, labor and recruitment areas, sources of data, and final availability percentage.

530:10-3-33.7. Utilization analysis

(a) Affirmative action plans for agencies authorized **15** or more full-time-equivalent employees shall include an analysis of the utilization of minorities and females in the agency's workforce ~~for as of~~ June 30th of each year.

(b) Appointing Authorities shall use a commonly-recognized statistical method to determine if underutilization exists, i.e., there are fewer minorities or women in a particular job group than would reasonably be expected by their availability.

(1) Agencies authorized less than **200** full-time-equivalent employees shall use the "80% method" to determine underutilization, unless another method is approved by the Administrator. The "80% method" declares underutilization to exist if the females or minorities in a job group are less than 80% of their availability or if the number of females or minorities in a job group is zero.

(2) Agencies authorized **200** or more full-time-equivalent employees ~~shall may~~ use the "80% method" as described in paragraph (1) of this subsection, or ~~may use~~ one of the following methods:

(A) The "whole person" method. When this method is used, underutilization is declared if the number of females or minorities is as much or more than one person below the number that would cause the job group representation percentage to match exactly the availability percentage.

(B) The "two standard deviation" method. When this method is used, underutilization is declared if the number of females or minorities in a job group is more than two standard deviations below availability.

(C) Another method approved by the Administrator.

(c) Appointing Authorities shall complete a form prescribed or approved by the Administrator to show a comparison of the actual employment of minorities and women with their

relative availability in the applicable job groups. The form shall provide spaces for summary information, including but not limited to: total staffing, numbers of minorities and females, final availability percentages, job group percentages, and determination of underutilization.

(d) A declaration of underutilization in an affirmative action plan shall not constitute an admission of wrongdoing or a determination that discriminatory practices are occurring in the agency.

PART 5. NONCOMPLIANCE, INVESTIGATIONS, HEARINGS, AND REMEDIES

530:10-3-54. Failure to make significant progress; pattern of noncompliance

(a) If, after notice and a hearing pursuant to Article II of the Administrative Procedures Act ~~[74:308a et seq.]~~ [75:308a et seq.], the Administrator finds that an agency has failed to make significant progress toward affirmative action goals or has a pattern of noncompliance with affirmative action goals, the Administrator may:

- (1) Require the *noncomplying appointing authority to participate in programs for special recruiting efforts* [74:840-2.1(G)(1)(a)];
- (2) Develop *training programs to enhance promotability of minorities within agencies and supervisory training in equal employment opportunity employment, affirmative action, managing workplace diversity* [74:840-2.1(G)(1)(b)];
- (3) Require *mandatory review and approval of all hiring decisions by an appointing authority by the Administrator if the Administrator can document a pattern of noncompliance in previous remedial actions pursuant to this subsection or appointment of a full-time affirmative action officer to any agency in noncompliance with affirmative action remedies* [74:840-2.1(G)(1)(c)].

(b) If the Administrator determines that none of the remedies in subsection (a) of this Section are appropriate, the Administrator may remove personnel function(s) relating to recruitment, hiring, or promotion from the appointing authority and place that function with the Administrator of the Office of Personnel Management. Removal of personnel functions under this subsection shall require:

- (1) A determination by the Administrator that a pattern of noncompliance with affirmative action goals exists at an agency;
- (2) A determination by the Administrator that the Office of Personnel Management has sufficient resources;
- (3) Documentation by the Administrator of a pattern of noncompliance with the affirmative action plan;
- (4) A vote by two-thirds of the Affirmative Action Council recommending that the Administrator remove personnel functions.

(c) Removal of personnel functions under subsection (b) shall terminate one calendar year from the removal of the function unless the Administrator is able to demonstrate that the restoration of personnel functions to the appointing authority

will result in further noncompliance with the affirmative action plan. A vote of two-thirds of the Affirmative Action Council shall be necessary to continue the removal of personnel functions for each additional year.

SUBCHAPTER 7. SALARY AND PAYROLL

PART 1. SALARY AND RATES OF PAY

530:10-7-1. Purpose and general provisions

(a) The purpose of the rules in this Part is to *establish pay regulations, regulations for performance pay increases, rates for pay differentials, on-call pay, and other types of pay incentives and salary adjustments* [74:840-1.6A].

(b) Pay raises are prohibited unless specifically authorized by legislation or the Merit Rules. A cost-of-living raise or any other type of raise that would be given to state employees on an across-the-board basis is prohibited unless specifically authorized by the Legislature [74:840-2.17].

(c) The rules in this subchapter provide for market adjustments, increases upon lateral transfer, skill-based adjustments, equity-based adjustments, career progression increases, salary adjustments upon completion of the initial probationary period or trial period, and performance-based adjustments. Appointing Authorities may use these pay mechanisms only if funds are available in the agency's budget for the current and subsequent fiscal year without the need for additional funding to increase the personal services budget of the agency. Upon certification from the Director of State Finance that an Appointing Authority has exceeded the agency's budget for the current or subsequent fiscal year due to the use of the pay movement mechanisms listed in this subsection, the Administrator may withdraw authorization for the agency to use the following pay movement mechanisms during the next appropriations cycle: market adjustments, increases upon lateral transfer, equity-based adjustments, performance-based adjustments, and career progression increases [74:840-2.17].

(d) The rules in this subchapter do not apply to employees and positions in the unclassified service unless stated otherwise.

530:10-7-6. Sign-on pay incentive

(a) Appointing Authorities may implement a pay incentive for the following individuals who are appointed to positions in job families for which there are critical recruitment and retention problems as identified by the Appointing Authority [74:840-1.6A(11)]:

- (1) individuals not currently employed in state government;
- (2) Carl Albert Executive Fellows and other professional trainees and students employed pursuant to paragraphs 10 and 11(a) and (b) of Section 840-5.5(A) of Title 74 of the Oklahoma Statutes; and
- (3) individuals employed pursuant to the Cooperative Engineering Trainee Program.

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(b) Appointing Authorities who choose to implement the pay incentive shall file a plan with the Administrator of the Office of Personnel Management and the Director of the Office of State Finance which contains information related to the implementation of the pay incentive within the agency. The plan shall provide documentation of the critical recruitment and retention problems and shall include a project description, specific prerequisites that each employee shall meet in order to receive the pay incentive, and information concerning the funding of the incentive from the agency's existing budget. The plan shall be signed by the Appointing Authority, and this signature requirement may not be delegated. No payment shall be made under this Section until the plan has been reviewed and accepted by the Administrator.

(c) The pay incentive shall not exceed \$5,000.00 and is payable to eligible individuals as a lump sum payment or in two equal payments during the first six months of state employment. Former state employees may be eligible for the pay incentive following a break-in-service of at least 180 days.

(d) To receive the pay incentive, an eligible individual shall be required to sign an agreement form acknowledging that the individual is obligated to repay the entire incentive, including tax withholdings on the incentive, if the individual leaves state employment or accepts employment with another state agency within 1 year after he or she receives the pay incentive. Appointing Authorities may use the agreement form developed by the Administrator or any other agreement form which is consistent with the provisions of this Section.

(e) An individual may receive only one sign-on pay incentive during his or her state employment.

530:10-7-7. Pay differential

(a) The Administrator may authorize a pay differential [74:840-1.6A(11)] for a position within a job family because of special duty requirements related to the position. This may include shift pay, on-call pay, skill-based pay adjustments, and other types of differentials based on special work requirements, as approved by the Administrator. These payments shall be over and above the employee's base pay and shall be paid only as long as the employee occupies the particular position under the circumstances which have necessitated the differential. The request for the differential shall be submitted in writing by the requesting agency and shall adequately identify the need.

(b) An Appointing Authority shall determine whether pay differentials will be paid while employees are in paid leave status or provided only for hours actually worked. Appointing Authorities shall apply such practices uniformly. Pay differentials shall not be provided for hours that an employee is not in pay status.

530:10-7-11. Continuous Service Incentive Plan

(a) Appointing Authorities may implement a pay incentive plan [74:840-1.6A(11)] intended to promote continuous service within the first two years of state employment. The plan shall be limited to job families for which there are critical recruitment and retention problems as identified by the Appointing Authority.

(b) The pay incentive shall consist of scheduled periodic payments over the employee's first two years of continuous service in the targeted job families, not to exceed a total of \$2,500 in any 12-month period. Payments may not be made prospectively or prorated. No payment shall be made under the plan until the employee has completed at least six months of continuous service in the targeted job family.

(c) At the discretion of the Appointing Authority, the following persons filling positions in the targeted job families may be included in the plan:

- (1) Persons not currently employed in state government;
- (2) Current state employees during their first two years of continuous state employment in the targeted job family; and
- (3) Former state employees following a break in service of at least 30 days.

(d) Appointing Authorities who choose to implement the pay incentive shall submit a written plan to the Administrator of the Office of Personnel Management and the Director of the Office of State Finance prior to implementation. The plan shall identify the job families to which the pay incentive will be applicable and shall document the critical recruitment and retention problems and the agency's rationale for the plan. The plan may provide for different pay incentives for different job families at the discretion of the Appointing Authority. The plan shall also identify the criteria for eligibility and shall include information concerning the funding of the pay incentive from the agency's existing budget. The plan shall be signed by the Appointing Authority, and this signature requirement may not be delegated. No payment shall be made under this Section until the plan has been reviewed and accepted by the Administrator.

530:10-7-12. Payment of overtime

(a) An Appointing Authority shall neither require nor allow employees to work in excess of **40** hours a week without establishing and implementing a comprehensive policy for compensation. Such policy shall be in compliance with the Fair Labor Standards Act (29 U.S.C. 201 et seq.). The policy shall be made available by the Appointing Authority to interested persons upon request and the Appointing Authority shall so notify employees. Copies of such policy shall be forwarded to the Office of Personnel Management. This section is not a comprehensive listing of the provisions of the Fair Labor Standards Act (29 U.S.C, 201 et seq.) and regulations promulgated thereunder, and is not intended to conflict with either the Act or the regulations.

(b) FLSA Non-Exempt (as defined by the Fair Labor Standards Act) employees shall be paid 1-1/2 times their regular hourly rate for each overtime hour worked.

(c) Compensatory time in lieu of overtime payment at the rate of time and one-half may be given to FLSA Non-Exempt employees (as defined by the Fair Labor Standards Act) subject to the following conditions:

- (1) Prior to the performance of overtime work, the Appointing Authority and the employee shall agree in writing that the employee may be required to take compensatory

time in lieu of overtime pay. A written agreement is not required with respect to employees hired prior to April 15, 1986, if the employer had a regular practice in effect on April 15, 1986, of granting compensatory time off in lieu of overtime pay (29 U.S.C. 553.23).

(2) An employee shall be permitted to use accrued compensatory time within **180** days following the pay period in which it was accrued. The balance of any unused compensatory time earned but not taken during this time period shall be paid to the employee. An Appointing Authority may request an extension of this time period for taking compensatory time off up to an additional **180** days providing the Appointing Authority submits proper documentation to the Office of Personnel Management justifying the extension. Agencies shall not be allowed to extend the initial 180-day time period for employees working in an institutional setting as defined by 74:840-2.15(D) [74:840-2.15(C)]. All extensions are subject to the approval of the Office of Personnel Management.

(3) The maximum compensatory time which may be accrued by a FLSA Non-Exempt employee shall be **480** hours for those employees engaged in a public safety or firefighting activity and **240** hours for all other FLSA Non-Exempt employees.

(4) An employee who has accrued the maximum number of compensatory hours shall be paid overtime compensation for any additional overtime hours worked at the rate of 1-1/2 times their regular hourly rate of pay for each overtime hour worked.

(5) Payment for accrued compensatory time upon termination of employment with the agency shall be calculated at the average regular rate of pay for the final **3** years of employment, or the final regular rate received by the employee, whichever is the higher.

(6) Overtime and compensatory time is accrued by work period, as defined by the FLSA.

(7) Compensatory time shall not be transferred from one agency to another agency.

(8) An Appointing Authority shall approve an employee's request to take compensatory time off on a particular day, unless the employee's taking compensatory time off on that day disrupts agency operations or endangers public health, safety, or property.

(9) Accrued compensatory time shall be exhausted before the granting of any annual leave for a non-exempt employee except when the employee may lose accrued leave under 530:10-15-10 and 530:10-15-11(b)(5).

(10) Adjustments in scheduled work time may be made on an hour-for-hour basis within the work period.

(d) Appointing Authorities may provide compensatory time off to FLSA Exempt (as defined by the Fair Labor Standards Act) employees with the following stipulations:

(1) The compensatory time off shall be taken within time periods and policy outlined in 530:10-7-12(c)(2). Unused compensatory time shall be taken off the books if not taken by the end of the time periods and policy outlined in 530:10-7-12(c)(2).

(2) Compensatory time shall only be given on an hour-for-hour basis, **1** hour off for each hour worked overtime. The maximum compensatory time which may be accrued by an FLSA exempt employee shall be the same as that outlined in 530:10-7-12(c)(3).

(3) Payments shall not be made for compensatory time accrued by an employee on FLSA Exempt status for any reason, except as provided for in (e) of this Section.

(e) After submitting written notice to the Office of Personnel Management, an Appointing Authority may provide overtime payments to persons in FLSA Exempt classes based on a prevailing market condition.

530:10-7-14. Rate of pay upon reclassification, promotion, career progression, demotion, and transfer

(a) **Rate of pay when incumbent is reclassified directly.** When an employee is reclassified directly under 530:10-5-90, the rate of pay shall be fixed in accordance with 530:10-7-13.

(b) **Rate of pay upon promotion or career progression.**

(1) An Appointing Authority shall adopt objective written criteria for the amount of salary advancements on promotion or career progression. These criteria shall be a part of the agency salary administration plan established under 530:10-7-1.1 and shall be consistent with state and federal statutes prohibiting discrimination.

(2) The Appointing Authority shall set an employee's salary on promotion or career progression at no less than 5% and no more than 20% of the employee's salary before promotion or career progression, except as follows:

(A) If the increase would make the employee's salary after promotion or career progression greater than the maximum rate of pay for the new pay band, the employee's salary shall be set at the maximum rate of pay for the new pay band.

(B) If the increase is insufficient to raise the employee's salary to the minimum of the new pay band, the employee's salary shall be raised to the minimum of the new pay band.

(C) The Appointing Authority may set the employee's salary on promotion or career progression at any more than 20% of the employee's salary before promotion or career progression as long as the rate is within the hiring range established for the position in an approved salary administration plan.

(D) The Appointing Authority shall not lower the salary of an employee on promotion or career progression. If the employee's salary before promotion or career progression exceeds the maximum of the new pay band, the employee's salary shall remain the same.

(c) **Rate of pay when demoted.** The rate of pay of an employee who is demoted shall be set by the Appointing Authority at any rate of pay within the pay band for the job to which demoted, which does not exceed that employee's last rate of pay. An Appointing Authority may delay setting the rate of pay upon demotion for up to **1** year when the demotion is due to an agency reorganization. For the purposes of this

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subsection, "agency reorganization" means the reclassification of employees in lieu of reduction-in-force.

(d) **Rate of pay upon intra-agency lateral transfer.** An Appointing Authority may provide up to a 5% increase in salary, not to exceed the maximum rate of pay for the pay band, for an employee upon intra-agency lateral transfer to a position in the same job family and level or another job family and level with the same pay band assignment, based on the needs of the agency. [74:840-2.17]

530:10-7-17. Rate of pay upon detail to special duty

The pay of an employee who is detailed to special duty in accordance with ~~530:10-5-110~~ 530-10-11-110 shall not be reduced, but must be increased to at least the minimum rate but not more than the maximum rate the employee could receive upon promotion to that job family and level, provided:

- (1) any such temporary increase shall not affect eligibility for increase in the regular job family and level which the Appointing Authority could grant if the employee had not been detailed.
- (2) at the conclusion of the detail, pay shall revert to the authorized rate of pay in the employee's regular job family and level.

SUBCHAPTER 9. RECRUITMENT AND SELECTION

PART 1. GENERAL PROVISIONS

530:10-9-4. Announcements

The Administrator shall make public announcements of all entrance examinations ~~at least 14 calendar days~~ in advance of the issuance of certificates. Such announcement shall include the waiting period between the date of the announcement and the release of names of eligible applicants to the appointing authority. An announcement may state the duties and salaries of positions in the jobs for which examinations are to be held; the qualifications required for admission to examinations; the time, place and manner of application; the proposed relative weights to be given the parts of the examination; and such other information as the Administrator may consider pertinent and useful.

530:10-9-5. Applications

An application for employment shall be made on a form prescribed by the Administrator and shall be considered part of the examination. The application form solicits information from the applicant regarding residence, veterans preference, education, training, experience and other eligibility information. The form may also ask for demographic information, such as race, sex, and ethnicity, for statistical analysis and state and federal record keeping and reporting requirements. Demographic information may also be used for special employment programs specifically authorized by law. Information provided by applicants shall be subject to verification. All applications

shall be signed in writing or by electronic signature by the applicant certifying the truth of all statements he or she made in the application. Applications must be filed with the Office of Personnel Management on or before the closing date specified in the announcements or postmarked before midnight on that date.

PART 3. WRITTEN AND PERFORMANCE TESTS

530:10-9-37. Repeating examinations

(a) A person may repeat a written test or performance test at ~~28 calendar day intervals and a performance test at 14 calendar day intervals that shall be determined and made public by the Administrator.~~

(b) ~~If the repeat interval for an examination differs from the standard repeat intervals listed in (a) of this Section, the Administrator shall notify the applicant in writing at the time of the original examination.~~

(c) ~~The repeat interval for a written or performance test shall apply to both entrance and promotional examinations. An applicant may request to be certified with a score on a written or performance test other than the most recent one, provided that the score requested on a written test is consistent with guidelines issued and made public by the Administrator, less than 4 years old and the score requested on a performance test is less than 1 year old. Otherwise, the examination is considered void.~~

530:10-9-38. Reviewing examinations

Applicants shall be entitled to inspect their own rating and examination papers maintained in the Office of Personnel Management up to 1 year after the date of the examination. Such inspection shall be permitted only during regular business hours at the Office of Personnel Management and shall include only those materials which would not compromise the security of the selection procedure. Any person who reviews an examination may not participate in the same examination for ~~60 calendar days from the date of review or for the repeat interval of the examination, whichever is greater.~~ a period of time designated by the Administrator consistent with guidelines issued and made public by the Administrator.

530:10-9-39. Identification numbers

~~The identity of persons taking written tests shall not affect score.~~ An identification number shall be used to identify all test materials of each applicant.

530:10-9-40. Test results

Applicants who take an examination shall be notified ~~in writing electronically~~ of the results. Applicants ~~may request information about the results of the examination and rating who have not provided an e-mail address shall be notified in writing.~~

PART 5. REGISTERS

530:10-9-51. Duration of registers; periods names may remain on registers

(a) The Administrator shall determine the duration of each register. After notice to affected eligibles, the Administrator may abolish a register or may shorten or extend the time that an eligible's name may remain on a register.

(b) If an eligible's name is not removed from a register under subsection (a) of this Section or other provisions of the Merit Rules, that eligible's name may remain on the register for a specific class for an ~~initial 6 month period and 6 month extension periods under the conditions listed in the following paragraphs:~~

~~(1) Extensions may be granted only on the basis of a written request from the applicant, and will extend the time on a register for a period of 6 months from the date of acceptance of the applicant's request by the Administrator.~~

~~(2) Any person whose name has been off a register for 3 months or more shall not be granted an extension. The person must submit a new application, a period consistent with guidelines issued and made public by the Administrator and applied uniformly to all applicants. Subsequent applications for a job will be accepted only if the register for that job is open for recruitment.~~

(3c) An applicant's name shall not appear on any register on the basis of a void examination as defined in 530:10-9-37.

530:10-9-52. Removal of names from registers

(a) In addition to the reasons set forth in 530:10-9-9, when a written request which states the reason for such action is received from an Appointing Authority or based upon an action of the Office of Personnel Management, the Office of Personnel Management may temporarily or permanently remove an eligible from a register for any of the following reasons:

- (1) Removal requested by eligible applicant.
- (2) Appointment through certification to fill a permanent position in the same job.
- (3) Failure to respond within 7 calendar days exclusive of the date of mailing of a written inquiry by the Appointing Authority relative to availability for appointment. Such inquiry shall include the date and time by which the eligible must contact the Appointing Authority.
- (4) Failure to respond within 72 hours to an e-mail message from the Appointing Authority relative to availability for appointment. Such inquiry shall include the date and time by which the eligible must contact the Appointing Authority and must be sent to the e-mail address provided by the eligible.
- (5) Failure to appear for a scheduled interview.
- (6) Declination of further consideration for selection.
- ~~(6)7~~ Declination of appointment.
- ~~(7)8~~ Failure to report for duty within the time specified by the Appointing Authority. (See 530:10-9-94.)
- ~~(8)9~~ Abolition of register by the Office of Personnel Management.

(b) Any person so affected shall be notified of this action and the reason for it. An eligible may request restoration to the register. If the Office of Personnel Management refuses to restore the eligible's name, such eligible may appeal to the Merit Protection Commission. At the appropriate time, the Administrator shall notify an individual of the right to appeal.

530:10-9-54. Restoration of names to registers

~~An eligible whose name is removed from a register may request restoration to the register. If the Office of Personnel Management refuses to restore the eligible's name, such eligible may appeal to the Merit Protection Commission.~~

PART 7. CERTIFICATION

530:10-9-76. Life of certificate

If an appointment is not made within ~~30~~ **90** calendar days of the date a certificate is issued, such certification shall be voided. ~~The Administrator may consider an Appointing Authority's written request to extend the life of a certificate for an additional 60 calendar days. All certificates issued shall be returned to the Office of Personnel Management within 30 calendar days after the void date.~~

PART 9. CLASSIFIED APPOINTMENTS

530:10-9-99. Fair employment practices appointments

(a) This Section establishes procedures for the application of the optional hiring procedure authorized by the Fair Employment Practices Act (FEPA), Section 840-4.12 ~~(H)~~(H) of the Oklahoma Personnel Act, *to employ females, blacks, Hispanics, Asian/Pacific Islanders and American Indians/Alaskan natives* ~~[74:840-4.12(I)(2)]~~ [74:840-4.12(H)(2)].

(b) An Appointing Authority intending to use the optional FEPA hiring procedure shall indicate that intention on a request for certification along with the targeted group, i.e., gender or race/ethnic category. An FEPA certification shall include a regular certificate with the availability of eligibles and ranking of names determined in accordance with the regular methods described in 530:10-9-71, **Certification methods**. An FEPA certification shall also include a separate list of the names of the top **10** available members of the targeted group. The Administrator may also include additional names as alternates. The names on this separate list shall be a subset of the regular certificate, and the names on it shall be ranked in the same order as on the regular certificate. If an Appointing Authority has targeted more than one group, a separate list shall be included for each group.

(c) If the Appointing Authority makes one or more appointments using an FEPA certification, each appointment shall be in accordance with either 530:10-9-92 or the optional FEPA hiring procedure authorized by Section 840-4.12 ~~(H)~~(H) of the Oklahoma Personnel Act.

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530:10-9-100. ~~Persons with Severe Disabilities Employment Program Optional Program for Hiring Applicants with Disabilities~~

(a) Appointing Authorities may employ persons with severe disabilities who are legal residents of Oklahoma through the ~~Persons With Severe Disabilities Employment Program Optional Program for Hiring Applicants with Disabilities~~ ("Program") [74:840-4.12]. Program participants shall meet all minimum qualifications of education and experience, but shall be exempt from entrance examinations and hiring procedures administered by the Office of Personnel Management [74:840-4.12]. Program participants shall be certified as having disabilities in accordance with the standards and procedures in subsection (b) of this Section [74:840-4.12]. Persons with severe disabilities are not required to participate in this Program, and they may elect to be considered for employment through regular selection procedures [74:840-4.12].

(b) The Department of Rehabilitation Services shall certify an applicant as having disabilities according to the definition for "individual with severe disability" in OAC 612:10-1-2, which the Administrator has established as the standard for disability certification, and shall provide electronic or written verification to the applicant and to the Office of Personnel Management. ~~An applicant shall present written verification to the Office of Personnel Management at the time he or she applies for employment.~~

(c) The Administrator shall give each Program applicant ~~submitting verification~~ certified according to (b), a letter of notification of all job family levels for which the applicant has applied and possesses the minimum qualifications of education and experience.

(d) ~~Effective April 1, 1996, letters~~ Letters of notification as described in (c) shall be valid for an initial ~~6~~ 12-month period. Applicants may renew eligibility ~~the letters~~ every ~~6~~ 12 months by notifying the Office of Personnel Management ~~in writing~~.

(e) An applicant for the Program may apply directly to employing agencies. In order to be eligible for appointment to fill a vacant position, an applicant shall be a legal resident of Oklahoma. The applicant shall submit to the Appointing Authority of the employing agency a current letter from the Administrator as described in subsections (c) and (d) indicating the applicant possesses the qualifications of education and experience for the vacancy.

(f) Persons with severe disabilities hired pursuant to this Program shall be subject to the Merit Rules [74:840-4.12].

PART 13. VETERANS PREFERENCE

530:10-9-130. Veterans preference on lists of eligibles

In establishing employment lists of eligible persons for competitive and noncompetitive appointment, certain preferences shall be allowed for veterans honorably discharged from the Armed Forces of the United States [74:840-4.14(A)].

(1) *Five points shall be added to the final grade of any person who has passed the examination and has submitted proof of having status as a:*

(A) *veteran* [74:840-4.14(A)(1)]; or

(B) *unremarried surviving spouse of a veteran* [74:840-4.14(A)(1)]; or

(C) *spouse of a veteran who is unemployable due to a service-connected disability as certified by the Veterans Administration or agency of the Defense Department within six (6) months of the date of application* [74:840-4.14(A)(2)].

(2) *Ten points shall be added to the final grade of any ~~war~~ veteran as defined in Section 67.13a of Title 72 of the Oklahoma Statutes who has passed the examination and has submitted proof of having a service-connected disability as certified by the Veterans Administration or Agency of the Defense Department within six (6) months of date of application* [74:840-4.14(A)(3)].

(3) In addition to the **10** points preference provided in (2) of this subsection, such eligible ~~war~~ veterans who are in receipt of benefits payable at the rate of **30%** or more because of the service-connected disability, shall be considered Absolute Preference Veterans. Their names shall be placed at the top of the register, ranked in order of their examination scores. Absolute Preference Veterans shall not be denied employment and passed over for others without showing cause. [74:840-4.14(A)(3)]

SUBCHAPTER 11. EMPLOYEE ACTIONS

PART 1. GENERAL PROVISIONS

530:10-11-1. Purpose

The purposes of the rules in this Subchapter are to establish policies and procedures for *probationary periods of employment* ~~[74:840-2.12(8)]~~[74:840-4.13(D)], transfers, promotions, demotions, and separations, while protecting *employees from arbitrary dismissal or unfair treatment* ~~[74:840-2.12(3)]~~[74:840-1.6(A)(3)].

PART 3. PROBATIONARY EMPLOYEES

530:10-11-31. Permanent status

Permanent status in the classified service shall not be granted until the probationary period has been successfully completed. Such status shall begin at the end of the final working day of the probationary period ~~[74:840-4.13(C)]~~[74:840-4.13(D)] except as otherwise provided in the following Sections: 530:10-11-30; 530:10-11-34; 530:10-11-36; and 530:10-11-32.

530:10-11-32. Termination during probationary period

The probationary appointment of any person may be terminated at any time during the probationary period without the right of appeal ~~[74:840-4.13(C)]~~[74:840-4.13(D)].

530:10-11-39. Transfer of probationary employees

A probationary employee shall not be transferred to a position in another job family level or agency except as provided in Section 840-2.21 of Title 74 of the Oklahoma Statutes, 530:10-15-49, or 530:10-11-74. No probationary employee appointed from a local certificate, issued in accordance with 530:10-9-71(b), shall be transferred from that locality until the probationary period has been completed.

PART 7. TRANSFERS AND VOLUNTARY DEMOTIONS

530:10-11-71. Intra-agency transfer

(a) The intra-agency transfer of a permanent employee from one position to another position in the same job family or another job in the same pay band, for which the employee has currently qualified, may be made at any time by the Appointing Authority. ~~Such transfer may be made simultaneously with a promotion or demotion in accordance with the provisions of the Merit Rules.~~

(b) Upon intra-agency lateral transfer, an employee shall serve a six-month trial period in the job level to which the employee is transferred, unless the trial period is waived in writing by the Appointing Authority. [74:840-4.12] If an employee does not prove to be satisfactory in the new job during the trial period, the employee may be reinstated to the former position or another in the same job family level, at the salary the employee would have received if the transfer had not taken place. The employee shall be informed in writing of any action taken pursuant to this provision.

(c) A state agency shall have sole and final authority to designate the place or places where its employees shall perform their duties. The Oklahoma Merit Protection Commission shall not have jurisdiction to entertain an appeal of an employee from action of the employing agency transferring the employee from one county or locality to another, changing the assigned duties of the employee, or relieving the employee from performance of duty at a particular place and reassigning to the employee duties to be performed at another place, unless:

- (1) the action results in a change in job classification or reduction of base salary; or
- (2) an investigation by the Commission indicates that a violation of the provisions of Section 840-2.5 or 840-2.9 of . . . [the Oklahoma Personnel Act] may have occurred; or
- (3) it is established that the action was clearly taken for disciplinary reasons and to deny the employee the right of appeal. [74:840-4.19]

SUBCHAPTER 13. REDUCTION-IN-FORCE

PART 1. GENERAL PROVISIONS FOR REDUCTION-IN-FORCE

530:10-13-1. Purpose

The purpose of the rules in this Subchapter is to implement the provisions of Sections 840-2.27A through ~~840-2.27C~~ 840-2.27(I) of the Oklahoma Personnel Act which pertain to reductions-in-force. The rules in this Subchapter establish general provisions for reductions-in-force and policies and procedures for recall and priority consideration for reemployment. The rules in this Subchapter governing reductions-in-force apply to classified employees within the executive branch only. This Subchapter is not a comprehensive listing of state and federal statutory provisions related to reductions-in-force and regulations promulgated thereunder, and is not intended to conflict with either state or federal law and regulations.

530:10-13-2. Definitions

In addition to terms defined in 530:10-1-2 and 455:10-1-2, the following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Affected job family levels" means those containing affected positions.

"Affected employees" means classified employees in affected positions.

"Affected positions" means positions being abolished or positions which are subject to displacement action.

"Agency" means any office, department, board, commission, or institution of all branches of state government, except institutions within The Oklahoma State System of Higher Education.

"Displacement or displace" means the process of an employee accepting an offer of employment to an occupied or funded vacant position.

"Displacement limit" means any area within an agency in which displacement may not occur. These areas may include, but are not limited to, job families, units, and geographic areas within an agency.

"Displacement opportunity" means the circumstances under which an occupied or funded vacant position is subject to displacement by an affected employee.

"Displacement privilege" means the privilege an affected employee has to utilize a displacement opportunity.

"Educational institution" means an institution within The Oklahoma State System of Higher Education, a facility under the management or control of the Oklahoma State Department of Vocational and Technical Education, or a licensed private educational institution in the State of Oklahoma.

"Personnel transaction" means the record of the separation as a result of a reduction-in-force of a classified affected employee from an agency, or the record of the transfer or demotion of a classified affected employee. [74:840-2.27B]

"Reduction-in-force" means abolition of positions in an agency or part of an agency and the corresponding nondisciplinary removal of affected employees from such positions through separation from employment or through displacement to other positions.

"Reorganization" means the planned elimination, addition or redistribution of functions or duties either wholly within an agency, any of its subdivisions, or between agencies.

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"Severance benefits" means employee benefits provided by the State Government Reduction-in-Force and Severance Benefits Act to affected employees separated through a reduction-in-force.

"Years of service" means current and prior service which is creditable for the Longevity Pay Plan. An affected employee shall not be required to have been continuously employed for two (2) years to be given credit for either current or prior service pursuant to the State Government Reduction-in-Force and Severance Benefits Act.

530:10-13-3. Notice of reduction-in-force and time requirements

(a) **Cabinet Secretary approval.** Prior to the posting of any reduction-in-force notice, the notice shall be approved by the cabinet secretary for the agency conducting the reduction-in-force. [74:840-2.27C] If there is no incumbent cabinet secretary for the agency, the approval requirement shall not apply.

(b) **Notice.** At least **60** days before the scheduled beginning of reduction-in-force separations or as otherwise provided by law, the Appointing Authority shall post a notice in each office affected by the proposed reduction-in-force that a reduction-in-force will be conducted in accordance with the Oklahoma Personnel Act and Merit Rules. Such notice shall be posted for **5** days. The Appointing Authority shall provide a copy of the notice to the Administrator. A reduction-in-force shall not be used as a disciplinary action. [74:840-2.27C(A)]

(c) **Implementation plan.** The reduction-in-force implementation plan and subsequent personnel transactions directly related to the reduction-in-force shall be in compliance with rules adopted by the Administrator. The reduction-in-force implementation plan, including the description of and reasons for displacement limits and protections from displacement actions, and severance benefits that will be offered shall be posted in each office affected by the plan within **5** business days after posting of the reduction-in-force notice. At the discretion of the Appointing Authority, the reduction-in-force implementation plan may be posted concurrently with the reduction-in-force notice. The reduction-in-force implementation plan shall:

- (1) Specify the position or positions to be abolished within specified units, divisions, facilities, agency-wide or any parts thereof, as determined by the Appointing Authority;
- (2) Provide for retention of affected employees based on type of appointment;
- (3) Require separation of probationary classified affected employees in affected job family levels, except those affected employees in probationary status after reinstatement from permanent classified status without a break in service, prior to the separation of any permanent classified affected employee in an affected job family level;
- (4) Provide for the retention of permanent classified affected employees in affected job family levels and those affected employees in probationary status after reinstatement, based on years of service;

(5) Provide for exercise of displacement opportunities by permanent classified affected employees and those affected employees in probationary status after reinstatement if any displacement opportunities exist; and

(6) Provide for outplacement assistance and employment counseling from the Oklahoma Employment Security Commission and any other outplacement assistance and employment counseling that may be available. [74:840-2.27C(B)]

(d) **Review of fiscal components.** The Director of the Office of State Finance shall, within **5** business days of receipt, review the fiscal components of the reduction-in-force implementation plan and reject any plan that does not meet the requirements of Section ~~840-2.27C(C)~~ 840-2.27C(D) of Title 74 of the Oklahoma Statutes.

PART 3. REDUCTION-IN-FORCE PLAN REQUIREMENTS

530:10-13-32. Order of employee removal

(a) Agency-wide, or within displacement limits, if established, retention of affected employees shall be based on job family level and type of appointment [74:840-2.27C]. Subject to eligible classified employees accepting displacement offers, unclassified employees in a job family level on limited term appointments shall be separated first, followed by employees on project indefinite appointments, followed by employees on probationary appointments with the agency, prior to the separation or voluntary demotion of any permanent classified employee from the same job family level [74:840-2.27C].

(b) Retention of permanent classified employees in affected job family levels and within displacement limits, if any are established, shall be based on years of service [74:840-2.27C].

(c) The Appointing Authority shall calculate retention points for all eligible classified employees, including those on an approved leave of absence. Eligible classified employees with more retention points shall be ranked higher; with the order of removal from a job family level in inverse order of that ranking. If tie scores occur, the ranking of employees who have the same total retention points shall be determined first by giving a veteran's preference over affected nonveterans who have equal retention points to the affected veteran and then by giving preference for retention according to years of service in the agency. If a tie continues to exist, retention status shall be determined by a method established by the Appointing Authority and described in the reduction-in-force implementation plan [74:840-2.27C].

(d) For purposes of a reduction-in-force, any permanent classified employee on a detail to special duty shall be ranked on the basis of base job family level, not on the basis of the job to which detailed.

SUBCHAPTER 15. TIME AND LEAVE

PART 1. GENERAL PROVISIONS

530:10-15-1. Purpose

The purpose of the rules in this Subchapter is to establish leave regulations ~~[74:840-2.12(11)]~~ ~~[74:840-1.6a(11); 74:840-2.20]~~ for classified and unclassified employees of the State of Oklahoma who are subject to leave rules. ~~[O]ffices and positions of the State Senate and House of Representatives shall not be subject to . . . [the Merit Rules governing] involuntary leave without pay or furlough. . . . No person chosen by election or appointment to fill an elective office shall be subject to any leave plan or regulation or shall such person be eligible for accrual of any leave benefits [74:840-5.1]~~

PART 3. ANNUAL AND SICK LEAVE POLICIES

530:10-15-10. General Annual and Sick Leave Policies

(a) Permanent and probationary classified employees and regular unclassified employees are eligible for annual leave and sick leave with full pay according to law and the rules in this Chapter. Temporary employees and other limited term employees are ineligible to accrue, use or be paid for sick leave and annual leave ~~[74:840-2.20(4)]~~ ~~[74:840-2.20(A)(3)]~~.

(b) The tables in Appendix B of this Chapter list leave accrual rates and accumulation limits. OAC 530:10-15-11 and 530:10-15-12 also govern annual and sick leave.

(c) Annual and sick leave accrual rates and accumulation limits are based on cumulative periods of employment calculated in the manner that cumulative service is determined for longevity purposes ~~[74:840-2.20(1)]~~~~[74:840-2.20(A)(1)]~~. For purposes of this Subchapter and the longevity pay program, cumulative service shall be calculated as prescribed in this subsection.

(1) State employment with any classified or unclassified agency in any branch of state government including service under the administrative authority of the Regents for Higher Education and the Department of Vocational and Technical Education shall be qualifying for purposes of calculating cumulative service. Cumulative service includes periods of part-time qualifying employment in excess of **2/5** time that were continuous for at least **5** months and any period of full-time employment described in (A) through (G) of this paragraph:

- (A) Employment as a permanent classified employee;
- (B) Employment as a probationary classified employee;
- (C) Employment as a regular unclassified employee;
- (D) Temporary or other time-limited unclassified employment;
- (E) Paid leave;
- (F) Leave without pay of **30** continuous calendar days or less; and
- (G) Leave without pay in excess of **30** calendar days taken under Section 840-2.21 of Title 74 of the **Oklahoma Statutes**. Any other leave without pay in excess of **30** calendar days shall not be counted as cumulative service.

(2) Periods of service that are described in (1) of this subsection, shall be combined for purposes of determining cumulative service and the total shall be expressed in whole years. Partial years, less than **12** months, are dropped.

(d) Annual leave and sick leave shall accrue only when an employee is actually working, on authorized leave with pay, or during the time the employee is using paid leave to supplement workers compensation benefits under Section 2e of Title 85. Leave shall not accrue after the last day the employee works.

(e) An employee using paid leave to supplement workers compensation benefits under Section 2e of Title 85 of the **Oklahoma Statutes** shall be in leave without pay status.

(f) An Appointing Authority may terminate an employee who is absent from work after the employee has exhausted all of his or her sick and annual leave accumulations unless the absence is covered by 530:10-15-45 or 530:10-15-49. Termination of a permanent classified employee under this subsection is subject to the pretermination hearing requirements of Section 840-6.4 of Title 74 of the **Oklahoma Statutes**. This subsection does not prevent an Appointing Authority from granting leave without pay according to 530:10-15-47.

PART 5. MISCELLANEOUS TYPES OF LEAVE

530:10-15-45. Family and medical leave

(a) The federal Family and Medical Leave Act of 1993 entitles eligible employees to family and medical leave. This section is not a comprehensive listing of the provisions of the federal Family and Medical Leave Act of 1993 (29 U.S.C, 2601 et seq.) and regulations promulgated thereunder, and is not intended to conflict with either the Act or the regulations. To be eligible, an employee shall have been employed by the state at least **12** months and have worked at least **1,250** hours during the preceding **12**-month period.

(b) An eligible employee is entitled to family and medical leave for up to a total of **12** weeks during any **12**-month period, for the following reasons:

- (1) the birth of the employee's son or daughter, and to care for the newborn child;
- (2) the placement with the employee of a son or daughter for adoption or foster care;
- (3) to care for the employee's spouse, son, daughter, or parent with a serious health condition. As used in this subsection, "son" or "daughter" means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing *in loco parentis*, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability; and
- (4) a serious health condition that makes the employee unable to perform the functions of the employee's job.

(c) An Appointing Authority may require that an employee's request for family and medical leave to care for the employee's seriously-ill spouse, son, daughter, or parent, or due to the employee's own serious health condition that makes the employee unable to perform one or more of the essential functions of the employee's position, be supported by a certification issued by

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the health care provider of the employee or the employee's ill family member.

(d) The entitlement to family and medical leave resulting from (b)(1) and (b)(2) of this Section expires at the end of the **12-month** period beginning on the date of the birth or placement.

(e) When family and medical leave is taken to care for a sick family member as defined in (b)(3) of this Section or for an employee's own serious health condition, leave may be taken intermittently or on a reduced leave schedule when it is medically necessary. An Appointing Authority may adopt a policy allowing family and medical leave to be taken intermittently to care for a newborn child or newly placed adopted or foster child.

(f) Whenever it is possible, an employee shall schedule family and medical leave to accommodate the operations of the employee's agency. An employee shall give the Appointing Authority notice and a leave request at least **30** days before leave is to begin if the need for family and medical leave is expected. When the need for family and medical leave is unexpected, an employee shall give the Appointing Authority notice and a leave request as soon as possible. The notice and request shall:

- (1) be in writing;
- (2) refer to this Section;
- (3) describe the reason for the family and medical leave;
- (4) specify the type of leave the employee is requesting to account for the time off; and
- (5) include any information or documentation required for the type of leave requested.

(g) The Appointing Authority has the responsibility to review requests for sick leave and leave without pay for designation as family and medical leave. The Appointing Authority has the right to designate leave taken for an FMLA-qualifying event as FMLA leave, regardless of whether the employee has requested FMLA leave. The Appointing Authority's designation decision shall be based only on information provided by the employee or the employee's spokesperson. In accordance with the federal Family and Medical Leave Act, the Appointing Authority shall not designate leave as family and medical leave retroactively, unless the Appointing Authority does not have sufficient information concerning the employee's reason for taking the leave until after the leave period has begun.

(h) Family and medical leave is not a separate type of leave, and it is not accrued or accumulated. An Appointing Authority shall give employees the following options to account for time lost because of leave under the federal Family and Medical Leave Act of 1993.

- (1) Charge to accumulated annual leave [74:840-2.22];
- (2) Charge to accumulated sick leave [74:840-2.22];
- (3) Charge to leave donated by other state employees under Section 840-2.23 of Title 74 of the **Oklahoma Statutes**, which is also known as "shared leave"; ~~and~~
- (4) Charge to accumulated compensatory time. If FMLA qualifying leave is paid with an employee's accrued compensatory time, the time shall not be charged

against the employee's 12-week FMLA entitlement [29 CFR 825.207(i)]; and

(4.5) Record as leave without pay in accordance with 530:10-15-47.

(i) The agency shall continue paying the employee's insurance coverage while the employee is on family and medical leave.

(j) Upon return from family and medical leave, an employee shall have the right to be restored to the same or equivalent position and benefits, except for extension of his or her anniversary date for longevity pay, leave accrual, and calculation of retention points, he or she would have had if the employee had been continuously employed in pay status during the leave period.

(k) An employee shall not be required to take more leave than necessary to resolve the circumstance that precipitated the need for leave.

530:10-15-49. Leave and first preference due to work related illness or injury

(a) **Purpose.** The purpose of this Section is to interpret Section 840-2.21 of Title 74 of the **Oklahoma Statutes** (Section 840-2.21). Section 840-2.21 establishes the rights and benefits of state employees who are absent from work because of an illness or injury arising out of and sustained in the course of employment with the State. These employees have a right to return to work if certain conditions are met. **In applying Section 840-2.21 and this Section, employing agencies shall return an employee to work as soon as possible, either to the original position or to an alternate position if an employee, with reasonable accommodation, is unable to return to the original position.**

(b) **Employee eligibility.** ~~This Section applies to all eligible probationary and permanent classified and regular unclassified employees. It does not apply to unclassified employees on temporary and other limited term appointments.~~ An employee shall file a claim for workers compensation benefits to be eligible [74:840-2.21].

(c) **Termination of rights.** All rights and benefits under Section 840-2.21 and this Section shall end **1** year after the start of leave without pay under this Section and shall end immediately if the claim for workers compensation is denied or ~~cancelled~~ otherwise concluded within the **1** year period [74:840-2.21].

(d) **Employing agency practice, policy, and procedure.** An agency's policy, procedure and practice affecting employees who file claims for workers compensation benefits shall agree with Section 840-2.21.

(e) **Required notice to employees.** Appointing Authorities shall give employees who report a job related illness or injury copies of this Section, Section 840-2.21, and the agency's policies and procedures for complying with this Section and the law. The procedures shall include instructions about requesting leave without pay under Section 840-2.21.

(f) **Placement of employee on leave without pay.** Appointing Authorities shall refer to this Section when they place an employee on leave without pay under Section

840-2.21. The Appointing Authority shall not require employees to exhaust paid sick and annual leave accumulations before placing them on leave without pay [74:840-2.21]. The Appointing Authority shall continue paying the employee's basic plan insurance coverage and dependent insurance benefit allowance while the employee is on leave without pay, and the leave shall not be a break in service [74:840-2.21].

(g) **Medical reports.** At least every **3** months, an employee on leave without pay under this Section shall give the Appointing Authority a medical statement as to his or her ability to perform the essential duties of the original position [74:840-2.21]. The medical statement shall be made by a physician as defined in Section 14 of Title 85 of the **Oklahoma Statutes**.

(h) **Inability to perform essential duties of original position.** If an employee on leave without pay under this Section cannot perform the essential duties of the original position, the employing agency shall give the employee first preference for other classified and unclassified positions according to Section 840-2.21.

(1) Appointing Authorities shall establish a procedure for giving employees on leave without pay under this Section first preference to fill classified and unclassified positions that do not represent a promotion to the employee, if the employee is medically able to do the essential duties and has the minimum qualifications for positions the Appointing Authority seeks to fill.

(2) The Appointing Authority's procedure shall include either notifying an employee of all vacant classified and unclassified positions the Appointing Authority seeks to fill or allowing the Appointing Authority and the employee to agree on notice for specific positions or jobs. The procedure may require employees to submit medical reports stating their ability to perform the essential duties of specific positions or groups of positions. The Appointing Authority shall give a copy of the procedure to each employee on leave without pay under this Section.

(3) Appointing Authorities do not have to notify employees on leave without pay under this Section when the Appointing Authority fills a vacant position temporarily (by temporary unclassified appointment or detail to special duty).

(4) Before an Appointing Authority may give a classified or unclassified employee first preference for a classified position, the employee shall be certified by the Office of Personnel Management as meeting the minimum qualifications. Neither classified nor unclassified employees shall be required to compete through the open competitive process for a classified position. The Appointing Authority shall submit the necessary paperwork to the Office of Personnel Management for review.

(5) Before an Appointing Authority assigns an employee to an alternate position (a position that is not the original position), the Appointing Authority shall give the employee written notice of the requirement to return to the original position under (i) of this Section. While in an alternate position, an employee shall submit medical reports at least every **3** months and whenever the medical

condition changes enough to affect his or her ability to return to the original position.

(i) **Return to original position.** An employee on leave without pay or working in an alternate position shall have the right to return to his or her original position according to this Section and Section 840-2.21. When a medical report indicates the employee is able to perform the essential duties of the original position, with or without reasonable accommodation, the Appointing Authority shall return the employee to the original position. The employee and the Appointing Authority may agree in writing to waive the requirement to return the employee to the original position from an alternate position.

(j) **Failure to return to work.**

(1) The Appointing Authority may discipline a permanent classified employee or a probationary classified employee or an unclassified employee if:

(A) a medical report states the employee is able to do the essential duties of the original position or an alternate position (for which the employee is qualified); and

(B) the employee does not return to work within **7** days after the Appointing Authority mails a notice to the employee's last known address or delivers a notice to the employee.

(2) If an employee does not return to the original position or an alternate position within **1** year after the start of leave without pay, the Appointing Authority may terminate the employee under Section 840-2.21. An Appointing Authority that uses Section 840-2.21 as authority to terminate an employee shall give the employee a copy of (k) of this Section. Termination of a permanent classified employee under this Section is subject to the pretermination hearing requirements of Section 840-6.4 of Title 74 of the **Oklahoma Statutes**.

(k) **Reinstatement upon separation.** A classified employee shall be eligible for reinstatement to either classified or unclassified employment with any state agency for **12** months after the date of separation under (j)(2) of this Section. An unclassified employee shall be eligible for reinstatement to unclassified employment with any state agency for **12** months after the date of separation under (j)(2) of this Section. This does not reduce eligibility under other general reinstatement or reemployment laws or rules, such as 530:10-9-102. [74:840-2.21]

**SUBCHAPTER 17. PERFORMANCE
EVALUATION AND SYSTEM AND CAREER
ENHANCEMENT PROGRAMS**

**PART 7. CARL ALBERT PUBLIC INTERNSHIP
PROGRAM**

530:10-17-74. Undergraduate internship program

(a) **Eligibility.** The undergraduate internship program consists of temporary positions for students enrolled in institutions of higher education and working toward an undergraduate

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degree ~~[74:840-3.4(1)]~~[74:840-3.4(A)(1)]. To be considered for eligibility determination, applicants shall have completed at least **24** semester hours of coursework with at least a **2.5** cumulative grade point average on a **4.0** scale. Applicants shall follow the procedures in 530:10-17-77 for eligibility determination.

(b) **Conditions of employment.** Participants in the Undergraduate Internship Program who receive internship appointments shall:

- (1) be employed in accordance with paragraph 8 of Section 840-5.5 of Title 74 of the Oklahoma Statutes, for not more than 2 semesters or 999 hours,
- (2) continue making progress toward an undergraduate degree,
- (3) maintain the grade point average set out in (a) of this Section, and
- (4) complete the training requirements described in (d)(3) of this Section.

(c) **Benefits.** Undergraduate interns shall not be eligible for paid leave, or health and retirement benefits.

(d) **Responsibilities of appointing authorities.**

(1) The Appointing Authority or designee shall ensure that the intern provides written verification to the Office of Personnel Management that the intern is:

- (A) continuing to make progress toward an undergraduate degree during each semester employed, and
- (B) maintaining the grade point average set out in (a) of this Section.

(2) If this information is not transmitted to the Office of Personnel Management within **30** days after the end of the previous semester, the Administrator shall notify the Office of State Finance and the Appointing Authority of the termination of the internship agreement in accordance with Section 530:10-17-82(a).

(3) Each Appointing Authority shall provide a minimum of 4 clock hours of job-related training for undergraduate interns during the internship, in addition to the training coordinated by the Administrator, and shall provide verification to the Office of Personnel Management of the completion of the training requirements.

530:10-17-75. Executive Fellows program

(a) **Eligibility.** An Executive Fellows Program consists of six-month to two-year placements in professional or managerial level positions for students ~~[74:840-3.4(2)(a)]~~[74:840-3.4(A)(2)]. No person is eligible to participate in the Executive Fellows program for more than **2** years. To be considered for eligibility determination, applicants shall have completed a baccalaureate degree and at least **6** semester hours of graduate level coursework with at least a **3.0** grade point average on a **4.0** scale [74:840-3.4(A)(2)] or a **7.0** on a **12.0** scale in all graduate level coursework. Applicants shall follow the procedures in 530:10-17-77 for eligibility determination.

(b) The Administrator may waive the completion of **6** semester hours of graduate level coursework required by subsection (a) of this section for **1** semester, if:

- (1) An individual currently employed by a state agency as a Carl Albert Public Internship Program undergraduate

intern provides written verification to the Office of Personnel Management that he or she has:

- (A) completed an undergraduate degree, and
- (B) is enrolled in **6** semester hours of approved graduate level work; and

(2) The Appointing Authority or designee of the agency where the undergraduate intern is currently employed certifies in writing on a form provided by the Office of Personnel Management that the agency intends to employ the undergraduate intern as a Carl Albert Public Internship Program Executive Fellow immediately upon the undergraduate intern's completion of an undergraduate degree.

(c) The appointment of an Executive Fellow in accordance with subsection (b) is not effective until the Administrator approves:

- (1) the waiver of the **6** semester hours of graduate level coursework; and
- (2) an Executive Fellow agreement form prepared by the Appointing Authority in accordance with 530:10-17-77(f).

(d) At the end of the semester for which the waiver of the **6** semester hours of graduate level coursework was approved by the Administrator pursuant to subsection (b), the individual employed as a Carl Albert Public Internship Program Executive Fellow shall meet the eligibility requirements in subsection (a) of this section or be removed from the Carl Albert Public Internship Program. [74:840-3.5]

(e) **Conditions of employment.** Participants in the Executive Fellows Program who receive internship appointments shall:

- (1) be appointed in accordance with paragraph 10 of Section 840-5.5 of Title 74 of the **Oklahoma Statutes** [74:840-3.5(4)],
- (2) be granted leave benefits commensurate with regular state employees [74:840-3.5(4)],
- (3) be enrolled in the state health insurance and retirement benefits programs, if expected to work one thousand (1,000) or more hours per year,
- (4) continue to make scholastic progress toward their graduate degrees during each fall and spring semester until completion of all graduate degree requirements,
- (5) maintain the grade point average set out in (a) of this Section, and
- (6) complete the training requirements described in (c)(3) of this Section.

(f) **Responsibilities of appointing authorities.**

(1) The Appointing Authority or designee shall ensure that the intern provides written verification to the Office of Personnel Management that the intern is:

- (A) continuing to make scholastic progress toward a graduate degree, until completion of all graduate degree requirements, and
- (B) maintaining the grade point average set out in (a) of this Section.

(2) If this information is not transmitted to the Office of Personnel Management within **30** days after the end of the previous semester, the Administrator shall notify the

Office of State Finance and the Appointing Authority of the termination of the internship agreement in accordance with Section 530:10-17-82(a).

(3) Each Appointing Authority shall provide a minimum of 8 clock hours of job related training for Executive Fellows during each 6-month period, in addition to the training coordinated by the Administrator, and shall provide verification to the Office of Personnel Management of the completion of the training requirements.

(4) Each Appointing Authority shall rate the performance of participants in the Executive Fellows Program in accordance with Section 840-4.17 of Title 74 of the Oklahoma Statutes. [74:840-3.4]

530:10-17-77. Application form and procedure

(a) Application form and applicant survey form.

(1) The Carl Albert Public Internship Program application is available from the Office of Personnel Management. The application form provides information about the application process and eligibility requirements. It solicits information about applicants and their qualifications for participation in the program.

(2) Applicants may apply at any time.

(3) An applicant may complete a voluntary survey form which solicits information related to demographics, including race or ethnic group, and disabilities. The information shall be used for statistical purposes only.

(b) Communication with the Office of Personnel Management. Interested persons may direct communications to the attention of the Carl Albert Public Internship Program in accordance with 530:1-1-12.

(c) Application procedure. Applicants for the internship program shall provide the following information to the Office of Personnel Management for review and determination of eligibility:

- (1) A completed and signed application form;
- (2) Transcript(s) of coursework from accredited higher education institutions;
- (3) A letter of nomination from a faculty member of the higher education institution where they are enrolled;
- (4) A letter of recommendation from the current Appointing Authority, if the applicant is a state employee ~~[74:840-3.4(4)]~~[74:840-3.4(C)];
- (5) A resume;
- (6) Three letters of recommendation from persons other than relatives or the nominating faculty member;
- (7) Verification of current enrollment.

(d) Notification. The Administrator shall notify applicants if the documents they submit are sufficient for eligibility. A notice of eligibility does not mean the applicant will be employed as an intern.

(e) Length of eligibility. Applicant information on file at the Office of Personnel Management shall remain active if eligible applicants submit verification of current enrollment and an updated transcript each semester. If applicants fail to provide updated information within 90 days after the end of the

previous semester, they will no longer be eligible for employment as an intern and their names will be removed from the list of eligible applicants made available to state agencies.

(f) Appointment.

(1) The Administrator shall provide a list of all eligible applicants for the Carl Albert Public Internship Program to state agencies periodically and at an agency's request. An agency may request an eligible applicant list and copies of individual eligible intern files at any time.

(2) An agency may appoint any eligible applicant after the Administrator has approved a completed Carl Albert Public Internship Agreement Form described in (3) of this subsection. A new form shall be completed if there are any substantive changes to the original agreement.

(3) The Administrator shall provide the internship agreement form to state agencies. The form solicits information about the employing agency, the Executive Fellow or Undergraduate Intern, and the internship faculty member. The form provides information regarding employment, benefits, training, work schedules, duties, compensation, and projected length of internship. Before an eligible applicant enters on duty, the agreement form shall be completed and signed by:

- (A) The eligible applicant;
- (B) The Appointing Authority or designee of the employing agency, who shall certify that the internship appointment does not contravene any provision of the Oklahoma Personnel Act or the Merit Rules;
- (C) The college or university faculty member who shall monitor the internship; and
- (D) A representative of the Administrator.

(4) All intern appointments are made at the discretion of the Appointing Authority. Executive Fellows will count against an agency's full-time-equivalent employee limit if an agency retains them after the internship time period is completed.

(5) The signature of the faculty member shall not be required when a Carl Albert Executive Fellow who has already completed his or her degree requirements is completing a new agreement form.

(g) State employees. State employees may apply to participate in the Carl Albert Public Internship Program. Permanent classified and regular unclassified employees who receive internship appointments may request leave without pay from their permanent or regular employment in accordance with 530:10-15-47, **Leave of absence without pay.** Probationary employees and regular unclassified employees with less than 12 months continuous service shall resign before entry-on-duty as an intern.

530:10-17-80. General conditions of employment

(a) No expectation of continued employment.

(1) Persons participating in the Carl Albert Public Internship Program shall be employed in the unclassified service of the state in accordance with Section 840-5.5 of Title 74 of the **Oklahoma Statutes** and Sections 530:10-17-74 and 530:10-17-75.

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(2) An intern has no right or expectation of continued employment in any classified or unclassified position with the state because of participation in the Carl Albert Public Internship Program.

(b) **Compensation plan for interns.**

(1) The employing agency shall establish compensation plans that include rates of pay for Carl Albert Public Internship Program positions which are consistent with positions having like duties and responsibilities within the agency.

(2) The Administrator may establish job descriptions for interns in accordance with Section 530:10-5-8.

(3) Carl Albert interns who are not exempt from the provisions of the Fair Labor Standards Act (29 U.S.C. 201 et seq.) are subject to its overtime provisions and 530:10-7-12.

(4) Salary adjustments may be made in accordance with Section 840-2.17 of Title 74 of the **Oklahoma Statutes**.

(c) **Report of work performance to educational institution.** The Appointing Authority or designee of the employing agency shall provide the internship faculty member with information necessary to evaluate the intern's work experience for academic purposes at the faculty member's request.

(d) **Intercession by the Office of Personnel Management.** The Office of Personnel Management may intercede in an internship if the Office determines, at the request of the intern, the agency, or the institution of higher education at which the intern is enrolled, that an internship is not functioning [74:840-3.5(7)][74:042-3.5(8)] in accordance with the rules in this Part, and the individual internship agreement. The intercession process may include, but is not limited to the following actions: modification of certain agreement terms, reassignment, and separation or early release from the internship.

(e) **State employees; continuation of benefits.** State employees leaving classified or exempt positions in state government in order to take an internship shall continue to receive all fringe benefits they would have received in their previous classified or exempt positions [74:840-3.5(2)].

(f) **Training requirements.** Each intern shall complete the training requirements prescribed by the employing agency and the Administrator.

PART 11. CERTIFIED PUBLIC MANAGER PROGRAM

530:10-17-110. Purpose

(a) The rules in this Part establish policies and procedures to implement the Certified Public Manager Program in accordance with Section ~~840-2.12(10)~~840-1.6A(10) of Title 74 of the **Oklahoma Statutes**. The Program is administered by the Administrator of the Office of Personnel Management.

(b) It is the purpose of the Certified Public Manager Program to develop the management skills of public sector employees and to assist state agencies and other public sector organizations in the identification and development of future leaders.

530:10-17-111. Definitions

In addition to words and terms defined in OAC 455:10-1-2 or 530:10-1-2, the following words and terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise.

"Organizations" means municipalities, counties, Indian Nations, and the federal government.

"Program" means the Certified Public Manager Program authorized by Section ~~840-2.12(10)~~840-1.6A(10) of Title 74 of the **Oklahoma Statutes**.

530:10-17-115. Program fees

(a) ~~State agencies and agency employees.~~

~~(1) The fee for participation shall be \$1,300.00 for candidates entering the Program on and after July 1, 1996 2006.~~

~~(2) The nominating state agency shall pay \$1,200.00 in two equal installments of \$600.00, payable in 2 fiscal years. The fee covers the cost of all required coursework, including course materials and instructor fees.~~

~~(3) The state agency employee shall pay \$100.00; \$10.00 for each of the four examinations and \$20.00 for each of the four three projects required for completion of the Program at the time the candidate sits for an examination or completes a project.~~

(b) ~~Organizations and organization employees.~~

~~(1) The fee for participation shall be \$1,600.00 for candidates entering the Program on and after July 1, 1996 2006.~~

~~(2) The nominating organization shall pay \$1,500.00 in two equal installments of \$750.00, payable in 2 fiscal years. The fee covers the cost of all required coursework, including course materials and instructor fees.~~

~~(3) the organization employee shall pay \$100.00; \$10.00 for each of the four examinations and \$20.00 for each of the three projects required for completion of the program at the time the candidate sits for an examination or completes a project.~~

(c) ~~Refunds. If a nominating agency or organization removes a candidate from the Program before the candidate has completed 60 required hours, the agency or organization shall:~~

~~(1) nominate another employee for the Program to replace the employee who was removed; or~~

~~(2) receive a refund from the Office of Personnel Management of one half of the prescribed total program fee. For example, if an agency has paid the first installment only, then there is no refund, but if an agency has paid both installments, then the agency shall receive the amount of one installment (one half the total).~~

(d) ~~Changes in fees. Changes in Program fees shall not affect fees for candidates who enter the Program before the effective date of the change.~~

(~~1~~a) The fee for participation shall be established by the Administrator pursuant to 74:840-1.6A(10).

(2b) Should the fee structure change during the course of an employee's participation in the program, fees shall remain consistent with the fee assessed at the time of enrollment.

[OAR Docket #07-656; filed 4-4-07]

**TITLE 530. OFFICE OF PERSONNEL MANAGEMENT
CHAPTER 10. MERIT SYSTEM OF PERSONNEL ADMINISTRATION RULES**

[OAR Docket #07-719]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 7. Salary and Payroll
- Part 1. Salary and Rates of Pay
- 530:10-7-24 [AMENDED]
- Subchapter 15. Time and Leave
- Part 5. Miscellaneous Types of Leave
- 530:10-15-43 [AMENDED]

AUTHORITY:

The Administrator of the Office of Personnel Management: 74 O.S., §§ 840-1.6A, 840-2.17, 840-2.19, and 840-2.20.

DATES:

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SUPERSEDED EMERGENCY ACTIONS:

None.

INCORPORATIONS BY REFERENCE:

None.

ANALYSIS:

The amendment to Title 530 amends 530:10-7-24 to require skill-based adjustments implemented on or after November 01, 2006 to be paid to an employee as long as the employee remains in the position utilizing the skills. The adjustment is not to be included as part of the employee's base salary. The amendments 530:10-15-43 amends this rule to address employees who work on holidays due to fire suppression duties. The amendments require the Appointing Authority to pay employees that work on a holiday due to fire suppression duties holiday pay based on a 8-hour workday times the employee's base rate of pay in addition to the employees normal rate of pay.

CONTACT PERSON:

Kara I. Smith, General Counsel, Office of Personnel Management, 2101 N. Lincoln, G-80, Oklahoma City, OK 73105, (405) 522-1736.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S.,

SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 7. SALARY AND PAYROLL

PART 1. SALARY AND RATES OF PAY

530:10-7-24. Skill-based pay adjustments

(a) An Appointing Authority may develop skill-based pay programs upon the approval of the Administrator. Such programs shall be related to the acquisition or possession of additional skills and abilities which can be applied to the work to be performed and which will increase the value of the employee to the agency. The skills or abilities must be verifiable through certification, licensure, diploma, or some other method and must be beyond the qualifications required to perform the primary or essential functions and responsibilities of the employee's position. Requests to establish skill-based pay programs shall include a complete description of the training or education required, how it will benefit the agency, the proposed salary adjustment, and any other information that will assist in evaluating the request.

(b) Skill-based pay adjustments may be provided as a differential over and above an employee's base pay or as lump-sum payment. Lump sum skill-based pay adjustments may be awarded upon initial certification and any subsequent recertification as may be required by the certifying organization and identified in the agency's skill-based pay plan. Lump sum payments shall be limited to 10% of an employee's annual salary, and differentials shall be limited to 10% of an employee's monthly salary for employees paid on a monthly basis, and 10% of an employee's biweekly salary for employees paid on a biweekly basis. Employees whose base pay is at or exceeds the maximum of the pay band shall not be eligible for a differential, but may receive a lump-sum payment. At no time shall a differential pursuant to this section cause an employee's base pay to exceed the pay band maximum. Except as provided in Subsection (c), skill-based pay adjustments shall be paid only as long as the employee occupies a position to which the skill is applicable in accordance with the agency's salary administration plan. An employee may receive multiple skill-based pay differentials so long as the combined total of all skill-based pay differentials does not exceed 15%.

(c) Skill-based pay differentials paid to an employee prior to November 1, 2006 shall become permanent after 24 continuous months and shall be included as a part of the employee's base pay, except as provided in 530:10-7-10. Skill-based pay differentials paid to an employee on or after November 1, 2006 shall not be included in the employee's base salary and are subject to being discontinued under circumstances described in Subsection (b). [74:840-2.17]

SUBCHAPTER 15. TIME AND LEAVE

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PART 5. MISCELLANEOUS TYPES OF LEAVE

530:10-15-43. Holidays

(a) Holidays shall be granted in accordance with state law and the Governor's proclamations as they are observed by the individual agencies in accordance with their work load and policies.

(b) To be eligible to receive holiday pay, an employee shall be in pay status or on furlough for the entire regularly-scheduled workday either the workday before or the workday after the holiday. An employee shall not be eligible to be paid for holidays which occur either before the employee's entry on duty date or after the last day the employee works. The receiving Appointing Authority shall pay an employee who transfers from another agency for any holidays occurring after the last day worked in the sending agency. An employee who is recalled, reemployed, or reinstated shall not be paid for any holiday occurring after the last day worked while previously employed and before entry on duty.

(c) Appointing Authorities shall pay full-time employees for holidays based on an 8-hour workday. Full-time employees who are eligible for holiday pay under (b) of this Section and who are scheduled to work either more or less than 8 hours on a holiday shall receive the equivalent of 8 hours of holiday pay or compensatory time off.

(d) Appointing Authorities shall prorate holiday pay for part-time employees based on one of the following methods:

- (1) Holiday pay as a percentage of normally scheduled hours worked divided by full-time hours; or
- (2) Holiday pay equal to regular pay for hours normally worked if a holiday occurs on a normally scheduled work day.

(e) If a full-time or part-time employee's scheduled hours worked plus holiday hours total less than the employee's normally scheduled hours during the workweek, the Appointing Authority shall account for the difference exercising one or more of the following options:

- (1) Work additional hours during the same workweek;
- (2) Charge to accumulated annual leave; or
- (3) Record as leave without pay under 530:10-15-47.

(f) If an employee's scheduled hours worked plus holiday hours are more than 40 hours in a workweek, the Fair Labor Standards Act requires that only hours actually worked be counted as hours worked in accordance with the Fair Labor Standards Act and 530:10-7-12.

(g) For employees who are scheduled required to work in fire suppression duties on a holiday, the Appointing Authority shall pay the employee for the holiday based on an 8-hour workday times the employee's base rate of pay at the time of payment. For employees who are required to work on a holiday in duties other than fire suppression and for employees whose regular day off falls on a holiday, the Appointing Authority shall either:

- (1) reschedule the employee's holiday to be taken within 180 days; or
- (2) pay the employee for the holiday based on an 8-hour workday times the employee's base rate of pay at the time of payment.

(h) An Appointing Authority may request an extension of the 180 days for taking holiday time off up to an additional 180 days providing the Appointing Authority submits proper documentation to the Office of Personnel Management justifying the extension. All extensions are subject to the approval of the Office of Personnel Management.

[*OR Docket #07-719; filed 4-6-07*]

TITLE 530. OFFICE OF PERSONNEL MANAGEMENT CHAPTER 15. VOLUNTARY PAYROLL DEDUCTION

[*OR Docket #07-655*]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Administrative Provisions
530:15-3-15 [NEW]

AUTHORITY:

The Administrator of the Office of Personnel Management; Title 62 O.S., § 7.10, Title 74 O.S., §§ 842 and 843 and Title 75 O.S., §§ 302, 305, and 307.

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SUPERSEDED EMERGENCY ACTIONS:

None.

INCORPORATIONS BY REFERENCE:

None.

ANALYSIS:

Subchapter 3-Amendment to Merit Rule 530:15-3-15: The rule is being amended throughout to reflect the statutory change promulgated by the legislature during the 2004 legislative session.

CONTACT PERSON:

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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTION 308.1(A), WITH AN EFFECTIVE DATE
OF MAY 11, 2007:**

SUBCHAPTER 3. ADMINISTRATIVE PROVISIONS

530:15-3-15. Annual distribution of employee organization materials

Appointing Authorities shall provide for the annual distribution of employee organization materials to agency employees. It shall be the responsibility of an employee organization to provide the materials to state agencies for distribution.

[OAR Docket #07-655; filed 4-4-07]

**TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM
CHAPTER 10. PUBLIC EMPLOYEES RETIREMENT SYSTEM**

[OAR Docket #07-610]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 1. General Provisions
- 590:10-1-18. Release of records [AMENDED]
- Subchapter 3. Credited Service
- 590:10-3-10. Incentive credit [AMENDED]
- Subchapter 7. Retirement Benefits
- 590:10-7-5. Selecting an option [AMENDED]
- 590:10-7-13. Filing for retirement and Initial retirement benefit [AMENDED]
- 590:10-7-16. Rollovers [AMENDED]
- Subchapter 9. Survivors and Beneficiaries
- 590:10-9-1. Survivors' benefits [AMENDED]
- Subchapter 19. Medicare Gap Benefit Option
- 590:10-19-2. Definitions [AMENDED]
- 590:10-19-4. Irrevocable election of Medicare Gap Benefit option [AMENDED]
- 590:10-19-5. Medicare Gap Benefit formula [AMENDED]
- 590:10-19-6. Eligible Members [AMENDED]
- 590:10-19-7. Eligibility exclusions [AMENDED]
- 590:10-19-8. Calculation of the Medicare Gap Benefit [AMENDED]

AUTHORITY:

Oklahoma Public Employees Retirement System Board of Trustees; 74 O.S., §§ 901, 909, 910, 913b, 913.4, 914, 915.3, 917, 918, 932

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SUPERSEDED EMERGENCY ACTIONS:

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Subchapter 7. Retirement Benefits
590:10-7-5. Selecting an option [AMENDED]

Gubernatorial approval:

August 24, 2006

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06-1279

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Subchapter 1. General Provisions
590:10-1-18. Release of records
[74 O.S. § 932]

This amendment deletes the requirement of OPERS to notify a member when a third party has requested and received information relating to the member's retirement file.

Subchapter 3. Credited Service
590:10-3-10. Incentive credit
[74 O.S. § 913b]

The amendment to this rule permits eligible members to transfer a participating service purchase to an addition to age purchase or an addition to age purchase to a participating service purchase.

Subchapter 7. Retirement Benefits
590:10-7-5. Selecting an option
[74 O.S. § 918]

This amendment clarifies how and to whom the benefits under an Option C retirement option are to be paid if the member or the designated beneficiary dies prior to the end of the ten-year certain payment period.

590:10-7-13. Filing for retirement and Initial retirement benefit
[74 O.S. § 914]

This amendment clarifies the rule regarding filing for retirement by requiring a properly completed retirement application before any benefits are payable.

590:10-7-16. Rollovers
[74 O.S. § 901 et seq.]

This amendment allows a non-spouse beneficiary to elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account or annuity. This amendment is necessary to comply with federal tax laws.

Subchapter 9. Survivors and Beneficiaries
590:10-9-1. Survivors' benefits
[74 O.S. §§ 913.4, 917, 918]

This amendment clarifies when a surviving spouse is eligible to receive the appropriate option benefit when the OPERS member dies before retiring or is eligible to vest or had elected a vested benefit prior to death.

Subchapter 19. Medicare Gap Benefit Option
590:10-19-2. Definitions
[74 O.S. § 915.3]

This amendment modifies and adds definitions to make the rule clear regarding the Medicare Gap Benefit Option.

590:10-19-4. Irrevocable election of Medicare Gap Benefit option
[74 O.S. § 915.3]

This amendment provides that the election of the Medicare Gap Benefit Option cannot be changed after the member's retirement.

590:10-19-5. Medicare Gap Benefit formula
[74 O.S. § 915.3]

This amendment clarifies how the Medicare Gap Benefit is determined.

590:10-19-6. Eligible Members

This amendment deletes surviving spouse as an eligible member who may elect this benefit.

590:10-19-7. Eligibility exclusions
[74 O.S. § 915.3]

This amendment clarifies who can elect the Medicare Gap Benefit Option.

590:10-19-8. Calculation of the Medicare Gap Benefit
[74 O.S. § 915.3]

This amendment clarifies the reference to the formula for the Pre-Medicare Increase.

CONTACT PERSON:

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Permanent Final Adoptions

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 1. GENERAL PROVISIONS

590:10-1-18. Release of records

(a) Pursuant to ~~2004 amendments to Section 74 O.S. § 932~~, a retired, vested or active member's name, age, amount of contributions paid in, benefits being paid, amount of credited service and documents verifying credited service or benefits may be released. All other information in a member's retirement file remains confidential. ~~The law specifically references members, therefore, no, including information or documents will be provided on~~ pertaining to joint annuitants or beneficiaries.

(b) ~~The System will do everything it can to protect members' information but still comply with the law. Therefore, the System~~ will only disclose information or records that are clearly required to be disclosed under the law. All requests for information must be in writing and state the specific information requested and the purpose for the request. The request must also specify the plan that it applies to. Requests which do not specify the plan name shall be presumed to apply to OPERS only. In addition, the request must provide sufficient information to easily identify the member. While a Social Security number may not be required, the date of birth, agency number, first and middle initial or other identifying information must be provided. Search and copy fees will be in accordance with OPERS adopted and published fee schedule.

(c) Information which does not currently exist does not have to be "created" nor does information have to be provided in a format or medium that does not currently exist.

(d) In order to comply with this provision, the following information may be supplied upon request:

- (1) Member's name - OPERS, URSJJ and SoonerSave computer records maintain only first and middle initials, and not the full name.
- (2) Member's age - In order to protect our members from potential identity theft, only the current age of the member expressed in whole years shall be provided in response to a general request for the age of a member.
- (3) Amount of contributions paid in - Contribution statements will show only employee contributions into OPERS and URSJJ. Employer contributions for individual employees are not complete. In response to a general request for a member's "contributions", only the employee contributions will be provided. If a specific request for employer contributions is made, we will provide a copy of the incomplete record with an explanation of the time period covered. For the SoonerSave accounts, the deferral amounts into the 457 Plan are not "contributions" and will not be disclosed. The employer contributions and the transfer of contributions to the Savings Incentive Plan

will be provided if specifically requested, however, the amount of interest or earnings will not be released as it is not a "contribution". All account balances for the Sooner-Save plans which reflect investment earnings will not be released.

(4) Benefits being paid - This information is available only for retired members of OPERS and URSJJ who are currently receiving benefits. SoonerSave does not pay "benefits", therefore, payments from the plan including any distribution amounts, hardship distributions or distribution schedules will not be released.

(5) Amount of credited service - This information may not be available for OPERS or URSJJ members who are active and have never had a benefit estimate completed. Therefore, general requests for credited service will be provided on retired or vested members only, and specific requests for credited service for active members will be provided only if the information exists in the file. Credited service is not relevant to or contained in the SoonerSave plans' records and cannot be provided.

(6) Any documents verifying credited service or benefits - This information will be provided only if specifically requested for OPERS and URSJJ. ~~Determinations regarding~~ The decision whether a document is used to verify credited service or benefits is discretionary and any release of these documents will be approved by the Executive Director on a case-by-case basis. The documents must have all confidential information redacted prior to being released. SoonerSave accounts do not contain information on either credited service or benefits, therefore, documents will not be released from the SoonerSave files.

(e) Information that is released must always have all Social Security numbers, home addresses and all telephone, pager or cell phone numbers redacted from any records or documents released, pursuant to 74 O.S. ~~Section §~~ 840-2.11. This will be done by removing or covering the confidential information to ensure that the information cannot be seen from either side of the page.

(f) Certain information contained in a member's file will remain confidential and will not be released without the member's permission. Examples of such information are:

- (1) Change of address records
- (2) Insurance information or documents
- (3) Any health care information
- (4) Any educational records
- (5) Tax records
- (6) Payroll deductions and withholdings
- (7) Medical documents of any kind
- (8) Copies of driver's license
- (9) Social Security numbers or copies of cards
- (10) Copies of birth certificates, death certificates or baptism documents
- (11) Copies of military records
- (12) Any bank account or banking information
- (13) Copies of passports or other forms of identification
- (14) Any unemployment information
- (15) Any worker's compensation information

(g) ~~OPERS policy is to notify each member when a third party has requested and received information that relates to his or her retirement file, including a copy of or identification of the provided information. However, this notification may not be practical and will not be made when information is provided as part of a group request and the information provided does not identify individual members.~~

(h) ~~This policy applies to member/participant information only. It does not apply to requests for general information regarding operations of the agency under the Open Records Act.~~

(ig) This rule is applicable to any plan or account managed or administered by the Board.

SUBCHAPTER 3. CREDITED SERVICE

590:10-3-10. Incentive credit

Pursuant to 74 O.S. §913(b) certain eligible members of the System may purchase up to two (2) full years of incentive credit at actuarial value.

- (1) Incentive credit may be used as participating service or addition to age.
- (2) Members are eligible for purchase of up to 2 years of credit (24 months).
- (3) Employees who are eligible for normal or early retirement because of age or are within 2 years of reaching normal or early retirement age, members who have accumulated at least 78 points toward the Rule of 80, and/or members who have accumulated at least 88 points towards the Rule of 90 are eligible for this purchase, except that elected officials may purchase incentive credit to qualify for the Rule of 80 only and Hazardous Duty Members may purchase incentive credit to qualify only for the Rule of 80 or 90 or for early retirement.
- (4) Incentive credit can not be used as full time equivalent employment. Members must have at least 4 years of the required 6 years of full time equivalent employment in order to be eligible for this purchase and must accrue 6 years of full time equivalent employment prior to retirement.
- (5) Members must be active and participating at the time of purchase or at the time of the transfer pursuant to paragraph (7) of this section.
- (6) This purchase may be amortized over sixty (60) months as provided for in 590:10-3-9.
- (7) ~~Although this was enacted as a retirement incentive, there is no requirement that members must retire if they make this purchase. Eligible members purchasing incentive credit pursuant to this section may transfer a participating service purchase to an addition to age purchase or an addition to age purchase to a participating service purchase. This transfer applies to purchases already made by an eligible member or to purchases currently being made through installment payments pursuant to 590:10-3-9. Full or partial installment payments made pursuant to this section shall not be refundable under any~~

circumstances. Transferring an incentive purchase to another incentive purchase pursuant to this paragraph may not result in an equal transfer.

SUBCHAPTER 7. RETIREMENT BENEFITS

590:10-7-5. Selecting an option

(a) The member may choose to receive the maximum benefit or receive benefits under any one of the retirement Options provided in 74 O.S., ~~See. § 918.~~

(1) The type of retirement benefit selected by the member and/or the member's spouse, if applicable, cannot be changed under any circumstances on or after the effective date of retirement, except as provided in this Section.

(2) In the event of the death of the named joint annuitant after the member's retirement date, the member shall provide the System with a copy of the joint annuitant's death certificate as notice of said death. The member's benefit will "pop-up" to reflect the amount of benefit the member would be entitled to absent the selection of an option. The "pop-up" increase becomes effective the first day of the month following the death of the joint annuitant, provided the member has given notice of said death. If the death of the joint annuitant occurred prior to June 30, 1994, the benefit increase may become effective with the July, 1994 benefit payment, provided the member has given notice of said death. Retrospective benefits will not be paid for any month prior to July, 1994; and are limited to a maximum of six (6) months. The "pop-up" increase is limited to members retiring with an Option A or Option B.

(b) A member choosing Option C provided in 74 O.S. § 918 shall be subject to the following provisions:

(1) In the event of the death of the retired member within the ten-year certain period under Option C, and there are no living designated beneficiaries, the person responsible for the estate of the deceased retired member shall be given the option for the estate to receive monthly benefits for the remainder of the ten-year period, or receive the present value of the remaining benefit payments in a one-time, lump-sum distribution.

(2) In the event the retired member predeceases a designated beneficiary within the ten-year certain period, and the designated beneficiary dies after the beneficiary has begun to receive benefits, the person responsible for the estate of the beneficiary shall be given the option for the beneficiary's estate to receive monthly benefits for the remainder of the ten-year period, or receive the present value of the remaining benefit payments in a one-time, lump-sum distribution.

(3) For purposes of this subsection:

(A) "person responsible for the estate" means the personal representative, executor or administrator of the estate as determined by a court of competent jurisdiction, or in the case of a probate waiver as permitted by 74 O.S. § 916.1, the appropriate claiming heir; and

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(B) "present value of the remaining benefit payments" means the lump-sum distribution shall be discounted using an interest rate equal to the actuarially assumed interest rate adopted by the Board of Trustees for investment earnings for the year in which the election is made pursuant to this subsection.

(4) The following shall be provided by the person responsible for the estate before any benefits will be paid:

(A) taxpayer identification number (TIN) for the estate, if applicable;

(B) legal documents naming the personal representative, executor or administrator of the estate, or in the case of a probate waiver, the appropriate documents as set forth in 74 O.S. § 916.1;

(C) certified copy of the death certificate for the member or beneficiary; and

(D) statement in writing from the person responsible for the estate selecting either the monthly or lump-sum payout method.

590:10-7-13. Filing for retirement and Initial retirement benefit

(a) It is the responsibility of all members to file a notice of retirement form with the System at least sixty (60) days but not more than one hundred eighty (180) days prior to the member's requested effective retirement date. Any member who has previously filed an application for vested benefit form will be considered to have met the sixty (60) day notice requirement; however, it is the responsibility of any such vested member to file a retirement form selecting the type of benefit to be paid prior to the member's requested retirement date. All retirement forms shall be prescribed, produced and approved by the System in order to constitute proper notice and retirement selection.

(b) The sixty (60) day notice requirement can be waived by application to the Board of Trustees. The application for waiver must state the reason for the request and grant of the waiver is at the sole discretion of the Board. Members are presumed to be familiar with the plan provisions and aware of the notice requirement and the Board will grant the waiver only for good cause shown. Good cause is generally shown in cases of an unforeseen hardship, such as illness of the member or a member's family or a reduction in force or layoff of employment. Good cause is also generally shown in cases of error or delay on the part of the employer and the error or delay is due to no fault of the member.

(c) No retirement benefits are payable until the System verifies that the member has been removed from the payroll; therefore, the initial retirement benefit payment to new ~~retirees~~ retirees shall be made at the end of the month following the month of retirement. Two benefit payments will be made at that time representing the month of retirement and the current month. Following this initial verification period, retirement benefits will be payable each month on the last day of that month.

(d) No retirement benefits shall be payable until the System receives a properly completed retirement form requesting such benefits. Unless otherwise specifically provided by law or by

these rules, no benefits shall be payable retroactively for any time period prior to receiving the member's properly completed retirement form regardless of when the member may have become eligible for such benefits. The requested retirement date of the member shall be made in accordance with the requirements of this section.

590:10-7-16. Rollovers

(a) This section applies to the Oklahoma Public Employees Retirement System and to the Uniform Retirement System for Justices and Judges.

(b) A distributee may elect to have eligible rollover distributions paid in a direct rollover to an eligible retirement plan the distributee specifies, pursuant to Section 401(a)(31) of the federal Internal Revenue Code.

(c) An eligible rollover distribution is any distribution of all or any portion of the balance to the credit of the distributee, except that an eligible rollover distribution does not include: any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of the distributee and the distributee's designated beneficiary, or for a specified period of ten years or more; any distribution to the extent such distribution is required under section 401(a)(9) of the Internal Revenue Code; the portion of any other distribution(s) that is not includible in gross income, except to the extent provided by paragraph (d) of this section; any distribution upon hardship of the employee; and any other distribution(s) that is reasonably expected to total less than \$200.00 during a year.

(d) A portion of a distribution shall not fail to be an eligible rollover distribution merely because the portion consists of after-tax employee contributions which are not includible in gross income. However, such portion may be transferred only to an individual retirement account or an individual retirement annuity described in section 408(a) or (b) of the Code or to a qualified ~~defined contribution~~ plan described in section 401(a) or 403(a) of the Code or to an annuity contract described in Section 403(b) of the Code that agrees to separately account for amounts so transferred, including separately accounting for the portion of such distribution which is includible in gross income and the portion of such distribution which is not so includible.

(e) An eligible retirement plan is an individual retirement account described in section 408(a) of the Code, an individual retirement annuity described in section 408(b) of the Code, an annuity plan described in section 403(a) of the Code, a qualified plan described in section 401(a) of the Code, an annuity contract described in section 403(b) of the Code, or an eligible deferred compensation plan described in section 457(b) which is maintained by an eligible employer described in section 457(e)(1)(A) of the Code, that accepts the distributee's eligible rollover distribution.

(f) A distributee includes an employee, ~~or former employee,~~ or for the limited purposes set forth in paragraph (h) of this section, a non-spouse beneficiary. In addition, the employee's or former employee's surviving spouse and the employee's or former employee's spouse or former spouse who is the alternate

payee under a qualified domestic relations order, as defined in section 414(p) of the Code, are distributees with regard to the interest of the spouse or former spouse.

(g) A direct rollover is a payment by the plan to the eligible retirement plan specified by the distributee.

(h) Effective January 1, 2007, a non-spouse beneficiary pursuant to section 402(c)(11) of the Code may elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account described in section 408(a) of the Code, or an individual retirement annuity described in section 408(b) of the Code, established for the purpose of receiving the distribution. A rollover pursuant to this paragraph shall be treated as a rollover of an eligible rollover distribution only for purposes of section 402(c) of the Code.

SUBCHAPTER 9. SURVIVORS AND BENEFICIARIES

590:10-9-1. Survivors' benefits

(a) If an active or retired elected official with a minimum of six (6) years of participating service dies, the surviving spouse is eligible to receive one half (1/2) of the elected official's benefit provided the elected official had met the service requirements for retirement. If a retired elected member selected an Option to apply to his/her service, the joint annuitant receives the Option benefit instead of the one half (1/2) benefit to the spouse.

(b) At the death of a member who is eligible to retire pursuant to law but is not actually retired, or is eligible to vest or had elected a vested benefit, the surviving spouse shall be entitled to receive the appropriate Option benefit as provided by law beginning at the date the deceased member would have become eligible to receive such benefits had the member survived. The System may withhold benefits to the surviving spouse until the necessary documentation is received and verified. The benefits payable shall accrue from the first day of the month following the death of the member if the deceased member met the requirements for an early or normal retirement.

SUBCHAPTER 19. MEDICARE GAP BENEFIT OPTION

590:10-19-2. Definitions

The following words or terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"**Board**" means the Board of Trustees for the Oklahoma Public Employees Retirement System.

"**Eligible Member**" means a member of the System who retires on or after the Option Effective Date and who is not Medicare-eligible at the time of retirement, ~~including Elected Officials, Hazardous Duty Members and the surviving spouse of a deceased Eligible Member,~~ except as otherwise provided in this Subchapter.

~~"Medicare Gap Benefit" means an actuarially determined adjusted retirement benefit which is greater than the member or beneficiary's member's Regular Retirement Benefit for months of payments prior to becoming Medicare-eligible and an actuarially reduced benefit which is less than the member or beneficiary's member's Regular Retirement Benefit for months of payments after becoming Medicare-eligible and for the remaining lifetime of the member and his or her joint annuitant.~~

"**Medicare Gap Benefit Election**" means an irrevocable election made by an Eligible Member prior to his or her effective date of retirement to receive the alternative benefit option payable pursuant to this Subchapter.

"**Medicare-eligible**" means age 65 or older, or such other age at which a member becomes eligible for Medicare benefits under federal law in effect at the time a member applies for an OPERS retirement benefit. For purposes of this Subchapter, age is calculated as of the first day of the month of birth. For example, a member born September 15, 1940, is considered to be 65 and Medicare-eligible on or after September 1, 2005.

"**Minimum Medicare Gap Benefit**" means a gross monthly benefit payment of \$200.00 per month after all applicable actuarial reductions for either the Pre-Medicare benefit or the Post Medicare benefit.

~~"Option Effective Date" means the date when the System will make made the Medicare Gap Benefit option available to Eligible Members. This date will be the first day of the third month following the System's receipt of written notice that the benefits provided in this Subchapter satisfy the tax qualification requirements applicable to governmental plans.~~

"**Post Medicare Benefit**" means the actuarially reduced monthly benefit payment ~~amount~~ for all months of retirement after the member becomes Medicare-eligible.

"**Pre-Medicare Benefit**" means the actuarially-increased monthly benefit payment ~~amount~~ for all months of retirement prior to the member becoming Medicare-eligible.

"**Pre-Medicare Increase**" means the amount added to the Regular Retirement Benefit to equal the Pre-Medicare Benefit.

"**Regular Retirement Benefit**" means the monthly retirement benefit that the Eligible Member would receive absent the Medicare Gap Benefit Election, which includes the actuarial adjustments as a result of the member's election of early retirement and/or survivor benefit options. It does not include amounts refunded of additional contributions paid to a member in the form of a limited retirement benefit under ~~Section 910.5 of Title 74-74 O.S. § 910.5.~~

"**System**" or "**OPERS**" means the Oklahoma Public Employees Retirement System.

590:10-19-4. Irrevocable election of Medicare Gap Benefit option

The Medicare Gap Benefit option election is an irrevocable election, ~~and is binding upon the member, his or her surviving spouse and/or joint annuitant. This election shall not be changed under any circumstances on or after the effective date of the member's retirement.~~

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590:10-19-5. Medicare Gap Benefit formula

(a) ~~The Medicare Gap Benefit shall be calculated using a formula which is designed to be the actuarial equivalent of the member's Regular Retirement Benefit subject to the actuarial reductions otherwise applicable as a result of election of early retirement or a survivor benefit option.~~

(ba) ~~The Medicare Gap Benefit formula for the Pre-Medicare Increase is not an individualized actuarial calculation. The formula for actuarial adjustment for the Medicare Gap Benefit shall be adopted annually by the Board prior to January 1 of each year. The formula shall be based upon the difference between the average of the non-Medicare Supplement premiums and average of the Medicare Supplement premiums for all health insurance plans offered by the Oklahoma State and Education Employees Group Insurance Board to inactive or retired OPERS members. The formula shall use the average premium amounts for the member only and shall include as an offset the amount of the health insurance subsidy payment made by the System. The amount of the adjustment Pre-Medicare Increase to a retiree's benefit prior to becoming eligible for Medicare, will not always equal the additional cost of the retiree's health insurance.~~

(eb) ~~The Medicare Gap Benefit formula Pre-Medicare Increase shall be reviewed and adopted by the Board prior to January 1 of each year to ensure that the benefit option has a neutral actuarial cost to the System formula is based upon new health insurance data.~~

(c) The Post Medicare Benefit is calculated using actuarially determined factors to reduce the benefit of the retiree thereby ensuring an actuarially neutral cost to the System.

(d) The Board shall adopt the appropriate actuarial tables to ensure the neutral actuarial cost to the System.

590:10-19-6. Eligible Members

Only Eligible Members may elect the Medicare Gap Benefit option. Any member ~~or surviving spouse~~ who has retired prior to the Option Effective Date of the Medicare Gap Benefit option is not eligible to make this election or change the type of retirement benefit previously selected. The Medicare Gap Benefit shall be paid only on a prospective basis.

590:10-19-7. Eligibility exclusions

Eligible Member specifically excludes any member ~~or surviving spouse~~ who receives retirement benefit payments for any months prior to the Option Effective Date, any member who is retiring under Disability Retirement, and any member ~~or surviving spouse~~ electing an Option C. ~~Surviving spouses of an employee killed or mortally wounded in the performance of his or her duties for the Department of Corrections receiving benefits under Subchapter 10 of Chapter 10 of these rules are not eligible to elect the Medicare Gap Benefit option.~~

590:10-19-8. Calculation of the Medicare Gap Benefit

(a) The mortality tables used in the calculation of the Medicare Gap Benefit shall be the same tables adopted by the Board for other OPERS calculations.

(b) The Pre-Medicare and Post Medicare Benefit payment amounts shall be calculated at the time of retirement and shall not be re-calculated after the member's effective retirement date except to correct errors or as specifically provided in these rules.

(c) ~~The Medicare Gap Benefit formula for the Pre-Medicare Increase is applied after the calculation of the Eligible Member's Regular Retirement Benefit which includes any required actuarial reductions made for early retirement or selection of Option A or B. The formula and shall be applied based upon the age of the member at time of retirement.~~

[OAR Docket #07-610; filed 3-30-07]

TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM CHAPTER 25. DEFERRED COMPENSATION

[OAR Docket #07-611]

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PERMANENT final adoption

RULES:

Subchapter 9. Benefits

590:25-9-17. Rollovers to other plans [AMENDED]

AUTHORITY:

Oklahoma Public Employees Retirement System Board of Trustees; 74 O.S. § 1701 et seq.

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Subchapter 9. Benefits

590:25-9-17. Rollovers to other plans

[74 O.S. § 1701 et seq.]

This amendment allows a non-spouse beneficiary to elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account or annuity. This amendment is necessary to comply with federal tax laws.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 9. BENEFITS

590:25-9-17. Rollovers to other plans

(a) Effective January 1, 2002, notwithstanding any provisions of the Plan to the contrary that would otherwise limit a ~~Distributee's~~ distributee's election under this Section, a ~~Distributee~~ distributee may elect to have any portion of an ~~Eligible Rollover Distribution~~ eligible rollover distribution paid directly to an ~~Eligible Retirement Plan~~ eligible retirement plan specified by the ~~Distributee~~ distributee in a direct rollover.

(b) ~~For purposes of a direct rollover, an Eligible Retirement Plan~~ As used in this section:

(1) "Eligible retirement plan", for purposes of a direct rollover, shall mean a qualified trust described in section 401(a) of the Code, an annuity plan described in section 403(a) of the Code, an individual retirement account described in section 408(a) of the Code, an individual retirement annuity described in section 408(b) of the Code, an annuity contract described in section 403(b) of the Code and an eligible plan under section 457(b) of the Code which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from this plan.

(~~2~~) ~~An "Eligible Rollover Distribution~~ rollover distribution" is ~~means~~ any distribution of all or any portion of the balance to the credit of the Distributee, distributee, except that an Eligible Rollover Distribution eligible rollover distribution does not include (i) any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Distributee, distributee, or the joint lives (or joint life expectancies) of the Distributee, distributee and the Distributee's designated beneficiary of the distributee, or for a specified period of ten (10) years or more; (ii) any distribution to the extent such distribution is required under Code Section 401(a)(9); (iii) the portion of any distribution that is not includable in gross income (determined without regard to the exclusion for net unrealized appreciation with respect to employer securities); or (iv) any amount that is distributed on account of hardship.

(~~3~~) ~~A "Distributee" includes a Participant or a Participant's surviving spouse, or for the limited purposes set forth in paragraph (c) of this section, a non-spouse beneficiary.~~

(c) Effective January 1, 2007, a non-spouse beneficiary pursuant to section 402(c)(11) of the Code may elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account described in section 408(a) of the

Code, or an individual retirement annuity described in section 408(b) of the Code, established for the purpose of receiving the distribution. A rollover pursuant to this paragraph shall be treated as a rollover of an eligible rollover distribution only for purposes of section 402(c) of the Code.

(~~d~~) ~~This~~ Except as otherwise provided, this section shall apply to distributions made after December 31, 2001.

[OAR Docket #07-611; filed 3-30-07]

TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM CHAPTER 35. DEFERRED SAVINGS INCENTIVE PLAN

[OAR Docket #07-612]

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RULES:

Subchapter 13. Benefits and Distributions 590:35-13-9. Rollovers to eligible retirement plan [AMENDED]

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Subchapter 13. Benefits and Distributions 590:35-13-9. Rollovers to eligible retirement plan [74 O.S. § 1707]

This amendment allows a non-spouse beneficiary to elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account or annuity. This amendment is necessary to comply with federal tax laws.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S.,

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SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MAY 11, 2007:

SUBCHAPTER 13. BENEFITS AND DISTRIBUTIONS

590:35-13-9. Rollovers to eligible retirement plan

(a) Notwithstanding any provision of the Plan to the contrary that would otherwise limit a distributee's election under this Section, a distributee may elect, at the time and in the manner prescribed by the Plan Administrator, to have any portion of an eligible rollover distribution paid directly to an eligible retirement plan specified by the distributee in a direct rollover.

(b) ~~Definitions~~ As used in this section:

(1) ~~"Eligible rollover distribution":—An eligible rollover distribution is~~ means any distribution of all or any portion of the balance to the credit of the distributee, except that an eligible rollover distribution does not include: any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of the distributee and the distributee's designated beneficiary, or for a specified period of ten years or more; any distribution to the extent such distribution is required under Code Section 401(a)(9); the portion of any other distribution(s) that is not includible in gross income, except to the extent provided by paragraph (c) of this section; and effective for distributions made after December 31, 2001, any amount that is distributed on account of hardship shall not be an eligible rollover distribution and the distributee may not elect to have any portion of such a distribution paid directly to an eligible retirement plan.

(2) ~~"Eligible retirement plan":—An eligible retirement plan is~~ means an individual retirement account described in Code Section 408(a), an individual retirement annuity described in Code Section 408(b), or a qualified trust described in Code Section 401(a), that accepts the distributee's eligible rollover distribution. However, in the case of an eligible rollover distribution to the surviving spouse, an eligible retirement plan is an individual retirement account or individual retirement annuity. Effective for distributions made after December 31, 2001, an eligible retirement plan shall also mean an annuity contract described in Code Section 403(b) and an eligible plan under Code Section 457(b) which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from this Plan. The definition of eligible retirement plan shall also apply in the case of a distribution to a surviving spouse, or to a spouse or former spouse who is the alternate payee under a qualified domestic relation order, as defined in Code Section 414(p).

(3) ~~"Distributee":—A distributee~~ means a Participant. In addition, the Participant or the Participant's surviving spouse are distributees with regard to the interest of the

spouse. For the limited purposes set forth in paragraph (d) of this section, distributee means a non-spouse beneficiary.

(4) ~~"Direct rollover":—A direct rollover is~~ means a payment by the Plan to the eligible retirement plan specified by the distributee.

(c) A portion of a distribution shall not fail to be an eligible rollover distribution merely because the portion consists of after-tax employee contributions which are not includible in gross income. However, such a portion may be transferred only to an individual retirement account or an individual retirement annuity described in section 408(a) or (b) of the Code, a qualified plan described in section 401(a) or 403(a) of the Code, or to an annuity contract described in section 403(b) of the Code that agrees to separately account for amounts so transferred, including separately accounting for the portion of such distribution which is includible in gross income and the portion of such distribution which is not so includible.

(d) Effective January 1, 2007, a non-spouse beneficiary pursuant to section 402(c)(11) of the Code may elect to have any portion of an eligible rollover distribution paid directly to an individual retirement account described in section 408(a) of the Code, or an individual retirement annuity described in section 408(b) of the Code, established for the purpose of receiving the distribution. A rollover pursuant to this paragraph shall be treated as a rollover of an eligible rollover distribution only for purposes of section 402(c) of the Code.

[OAR Docket #07-612; filed 3-30-07]

TITLE 775. BOARD OF VETERINARY MEDICAL EXAMINERS CHAPTER 10. LICENSURE OF VETERINARIANS, VETERINARY TECHNICIANS AND ANIMAL EUTHANASIA TECHNICIANS

[OAR Docket #07-599]

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RULES:

Subchapter 3. Licensure of Veterinarians

775:10-3-8.1. Requirements for obtaining faculty licensure [AMENDED]

775:10-3-8.2 [RESERVED]

775:10-3-8.3. Provisional License [NEW]

775:10-3-12. Fees [AMENDED]

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The proposed revisions to chapter 10, includes requirement for a Faculty license applicant to take and pass the Jurisprudence examination and addition of a Provisional license for veterinarians.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2007:

SUBCHAPTER 3. LICENSURE OF VETERINARIANS

775:10-3-8.1. Requirements for obtaining faculty licensure

(a) The Board may, within its discretion, issue a Veterinary Faculty License.

(b) Candidates for Veterinary Faculty License have the burden to furnish the Board with evidence on the following issues, to-wit:

(1) Applicant must submit proof that he/she holds or will hold a veterinary faculty position at one of the state's institutions of higher learning and that such position will involve the Applicant in the instructional program of either undergraduate or graduate veterinary medical students. Such faculty position and duties shall be certified by an authorized administrative official at the educational institution. The Board will review other applicants on individual merit and position sought in the interest of the public.

(2) Applicant is a graduate of a college of veterinary medicine approved by the American Veterinary Medical Association (AVMA) or certified by the Education Council on Foreign Veterinary Graduates (ECFVG); or Applicant may have passed the National Board Examination (NBE), the Clinical Competency Test (CCT), or North American Veterinary Licensing Examination (NAVLE); or be currently licensed in good standing in another state, or be board certified in a specialty recognized by the AVMA.

(3) Applicant must be prepared for personal interview with the Board or its designee to provide evidence of competency in their specialty or subspecialty and their ability to communicate in the English language.

(4) For veterinarians whose native language is not English and who have graduated from AVMA-approved or accredited colleges, in addition to requirements (1) through (3) of this subsection, the Board may require satisfactory completion of the same English competency tests used by the ECFVG. Currently these tests include the Test of English as a Foreign Language, Test of Written English and Test of Spoken English.

(5) Applicant is required to take and pass the Oklahoma Jurisprudence examination before issuance of a Faculty license.

(c) Any Veterinary Faculty license is valid only for the practice of veterinary medicine as a faculty member of the aforesaid educational institution.

(d) Any Veterinary Faculty License is limited only to the specialty or subspecialty that the Applicant teaches at the educational institution, and shall be enumerated on the application and on the license.

(e) Any fees charged for the professional veterinary services of the holder of a Veterinary Faculty License shall be equal to that charged by fully licensed veterinary practitioners in the area. All fees received for the professional veterinary services provided by a veterinary faculty licensee shall go to the educational institution and the holder of any Veterinary Faculty License shall be reimbursed for practice aspects of his services only from federal, state or institutional funds, not from clients.

(f) Each person holding a Veterinary Faculty License must at all times clearly identify and represent himself as a veterinary faculty licensee.

(g) Each person holding a Veterinary Faculty License must renew that license prior to ~~June 30~~ July 15 each year.

775:10-3-8.2. [RESERVED]

775:10-3-8.3. Provisional License

(a) The Board may, within its discretion, issue a provisional license with such restrictions and limitations as the Board deems appropriate.

(b) Qualifications. Candidates for a provisional license must fulfill the following criteria:

(1) Must be licensed to practice veterinary medicine in another jurisdiction.

(2) Completion of application and payment of all fees.

(3) The provisional license to practice will not exceed a period of 60 days in any 12-month period.

(4) Candidates are required to take and pass the Oklahoma Jurisprudence examination before issuance of the provisional license.

775:10-3-12. Fees

(a) **Fee Schedule.**

(1) **Examination.** The following fees shall be assessed for licensure and examination of veterinarians:

(A) North American Veterinary Licensing Examination - At Cost + \$185.00

(B) Oklahoma State Examination - \$150.00

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(2) **Licensure.** The following fees shall be assessed for licensure of veterinarians:

- (A) Annual renewal (prior to June 30) - \$175.00
- (B) Annual renewal Faculty License (prior to ~~June 30~~ July 15) - \$175.00
- (C) Reactivation fee (between July 1 and August 29) - \$275.00
- (D) Reinstatement fee (after August 30) - \$625.00
- (E) Licensure by Endorsement - \$625.00
- (F) Faculty License - \$125.00
- (G) Provisional License - \$300.00

(3) **Duplication or modification of license.** A fee of \$50.00 shall be assessed for duplication or modification of a veterinary license.

(4) **Supervised Doctor of Veterinary Medicine.** The following fees shall be assessed for certification as a supervised doctor of veterinary medicine:

- (A) Original Certificate - \$125.00
- (B) Extension - \$100.00
- (C) Transfer - \$50.00

(5) **Miscellaneous fees.** The following miscellaneous fees shall be assessed by the Board.

- (A) Certification of scores - \$40.00
- (B) Verification of license - \$20.00
- (C) Duplication of proof of renewal of license - \$10.00
- (D) Certification of public records (per page) - \$1.00
- (E) Duplication of public records (per page) - \$.25
- (F) Transcript of public records recorded (per page) - At Cost
- (G) Issuance of subpoena - \$.25
- (H) Returned check processing fee - \$35.00

(I) Probation fees:

- (i) \$50.00/month, unless otherwise modified by the Board or the Secretary/Treasurer
- (ii) Investigation/Prosecution - at cost (Non-payment of investigation, prosecution or probation costs or fees within 30 days of billing may be grounds for imposition of additional sanctions by the Board).

(J) Declaratory ruling - \$300.00 plus costs.

(6) **Registered Veterinary technician fees.** The following registered veterinary technician fees shall be assessed by the Board:

- (A) National Veterinary Technician Examination - at cost
- (B) State Examination - \$60.00
- (C) Application Processing Fee - \$50.00
- (D) Certificate - \$20.00
- (E) Annual Renewal - \$45.00

(7) **Animal Euthanasia technician fees.** The following animal euthanasia technician fees shall be assessed by the Board:

- (A) Training and Practical Examination - At cost
- (B) Oklahoma State Bureau of Investigation criminal history search - At cost
- (C) State Written Examination - \$60.00
- (D) Application Processing Fee - \$50.00
- (E) Certificate - \$20.00
- (F) Annual Renewal - \$40.00
- (G) Reactivation fee - \$25.00

(b) **Submission of fees.** All fees are non-refundable.

[OAR Docket #07-599; filed 3-30-07]

Executive Orders

As required by 75 O.S., Sections 255 and 256, Executive Orders issued by the Governor of Oklahoma are published in both the *Oklahoma Register* and the *Oklahoma Administrative Code*. Executive Orders are codified in Title 1 of the *Oklahoma Administrative Code*.

Pursuant to 75 O.S., Section 256(B)(3), "Executive Orders of previous gubernatorial administrations shall terminate ninety (90) calendar days following the inauguration of the next Governor unless otherwise terminated or continued during that time by Executive Order."

TITLE 1. EXECUTIVE ORDERS

1:2007-12.

EXECUTIVE ORDER 2007-12

I, Brad Henry, Governor of the State of Oklahoma, pursuant to the authority vested in me by the provision of Section 256 of Title 75 of the Oklahoma Statutes do hereby order:

A. The following executive orders placing various agencies or parts of agencies under the merit system shall remain in full force and effect:

1. The unnumbered executive orders issued by the Honorable J. Howard Edmondson:

Dated November 6, 1959 concerning the current Employment Security Commission and the Department of Health

Dated December 3, 1959 concerning the Civil Defense Department, Office of Division of the Budget, now referred to as the Office of State Finance, Board of Cosmetology and the Office of the State Reformatory

Dated December 9, 1959 concerning the current Office of Professional Engineers, now referred to as the Board of Registration for Professional Engineers and Land Surveyors and the Office of the State Securities Commission, now referred to as the Department of Securities

Dated January 6, 1960 concerning the current Office of State Personnel Board, now referred to as the Office of Personnel Management

Dated January 22, 1960 concerning the Historical Society, Commission of the Land Office, now referred to as the Office of the Land Commissioners, the Oklahoma Cerebral Palsy Commission now referred to as the J.D. McCarty Center for Handicapped Children, Department of Public Safety, Water Resources Board

Dated March 3, 1960 concerning the current Liquefied Petroleum Gas Board and the Adjutant General's Department, now referred to as the Military Department

Dated March 7, 1960 concerning the current Department of Agriculture and Department of Libraries

Dated April 4, 1960 concerning the current Department of Highways, now referred to as the Department of Transportation

Dated May 5, 1960 concerning the current Soil Conservation Board, now referred to as the Conservation Commission

Dated May 27, 1960 concerning the Department of Mental Health

2. The unnumbered Executive Orders issued by the Honorable Henry Bellmon:

Dated January 18, 1965 concerning the current Office of the Oklahoma Capitol Improvement Authority

Dated April 28, 1966 concerning the current State Fire Marshal, now referred to as the State Fire Marshall's Commission, Board of Pharmacy, Real Estate Commission, Oklahoma Turnpike Authority, Will Rogers Memorial Commission and Oklahoma Aeronautics Commission

Dated June 23, 1966 concerning the Grand River Dam Authority

Dated August 24, 1966 concerning the Cerebral Palsy Center, now referred to as the J.D. McCarty Center for Handicapped Children

Dated September 15, 1966 concerning the current Oklahoma State Retirement System, now referred to as the Public Employees Retirement System

3. The unnumbered Executive Orders issued by the Honorable Dewey Bartlett:

Dated October 11, 1967 concerning the current Department of Corrections

Dated September 5, 1968 concerning the current Oklahoma State Bureau of Investigation

4. The unnumbered Executive Order issued by the Honorable David Hall:

Dated December 2, 1974 concerning the current Department of Consumer Affairs, now referred to as the Department of Consumer Credit

Executive Orders

5. The Executive Orders issued by the Honorable David Boren in 1978:

22 Carl Albert Community Mental Health Center

23 Jim Taliaferro Community Mental Health Center

6. The Executive Orders issued by the Honorable George Nigh:

79-8 Central Oklahoma Community Mental Health Center

80-4 Phil Smalley Children's Center

85-8 Department of Health

86-29 Oklahoma Pecan Commission

86-30 Office of Handicapped Concerns

86-31 Board of Governor's of the Registered Dentists

86-32 Oklahoma State Board of Embalmers and Funeral Directors

86-33 Board of Medical Examiners now referred to as the State Board of Medical Licensure and Supervision

86-34 Oklahoma Motor Vehicle Commission

86-35 State Board of Osteopathy now referred to as the State Board of Osteopathic Examiners

86-36 Oklahoma Peanut Commission

86-37 Sheep and Wool Utilization, Research and Market Development Commission now referred to as the Sheep and Wool Commission

86-38 Oklahoma State Insurance Fund

86-41 The Department of Pollution Control now referred to as the Department of Environmental Quality

86-42 Commission on Children and Youth

7. The Executive Order issued by the Honorable Henry Bellmon:

91-1 Highway Safety Division of the Oklahoma Department of Transportation

8. The Executive Orders issued by the Honorable Frank Keating:

98-11 Oklahoma State and Education Employees Group Insurance Board

98-12 Oklahoma Ethics Commission

B. The following additional Executive Orders shall remain in full force and effect:

1. The following additional Executive Orders issued by the Honorable David Walters:

91-10 establishing the Governor's Council on Physical Fitness

91-19 establishing the position of State Geographer

94-16 designating the Secretary of the Environment to be responsible to disburse certain funds for the State

2. The following additional Executive Orders issued by the Honorable Frank Keating:

93-20 (as amended on 9/5/02) establishing the Developmental Disabilities Council

95-6 designating the DHS Director to be the State Administrator of the federal food stamp program

95-7 designating the Oklahoma Housing Finance Agency to administer the federal housing credit program

95-10 establishing the Governor's Advisory Council on Asian-American Affairs

95-16 establishing the Oklahoma Commission on the Deaf and Hearing Impaired

95-24 Game Warden law enforcement

96-07 designating Office of Juvenile Affairs as agency responsible for state juvenile justice plans

96-08 designating the Oklahoma Community Service Commission to oversee the State's participation in federal volunteer & other program

96-26 establishing the Governor's Advisory Council on Latin American and Hispanic Affairs

96-27 directing Executive Department agencies, boards and commissions with access to the Internet to develop an internal policy prohibiting child pornography and other obscene materials

97-08 designating the Director of DCS to issue emergency declarations closing state buildings when unsafe working conditions exist

97-12 designating the Oklahoma Amateur Sports Commission to advise Governor on the promotion of amateur sports

98-32 establishing the State of Oklahoma Emergency Standard Operating Procedures

98-37 establishing procedures for local project funding contracts when contracts are not covered by competitive bidding statutes

2001-22 establishing Oklahoma's Bioenergy Initiative

2001-25 establishing the Governor's Task Force on Foreign Animal Diseases

2001-27 designating the DHS Director to be the State Administrator of the federal Improved Independent Living Program

2001-33 establishing the Governor's Task Force on Health Insurance Portability and Accountability

3. The following Executive Orders issued by the Honorable Brad Henry:

2003-9 creating Governor's Committee on Homeland Security funding

2003-16 establishing a State Citizen Corps Council under Department of Civil Emergency

2003-22 requiring certification and submission of payrolls for payment

2003-29 appointing Commissioner of Department of Public Safety as Governor's designee for advising when hazardous weather conditions exist

2004-1 clarifying powers for Secretary of Environment

2004-10 creating the Governor's Interagency Council on Homelessness

2004-13 creating AMBER plan for Oklahoma

2004-15 appointing Major Kerry Pettingill as Oklahoma Homeland Security Director

2004-21 establishing the Governor's Ethnic American Advisory Council

2004-38 State government work places shall be free from illegal manufacture, distribution, dispensation, possession or use of any controlled substance

2005-6 specifying purpose and duties of Oklahoma Homeland Security Director and Oklahoma Emergency Management Director

2005-20 establishing the Governor's Health Care Workforce Resources Task Force

2005-27 establishing the Governor's Council for Workforce and Economic Development to serve as the State's Workforce Investment Board

2005-34 establishing the Governor's Transformation Advisory Board to advise the state as it develops a Comprehensive Mental Health Plan

2006-4 re-establishing the Interagency Coordinating Council for Early Childhood Intervention

2006-10 state holidays in 2007

2006-20 creating United We Ride Council

2006-24 observing November 16, 2007, Statehood day, as a holiday

2006-28 designating Director of Oklahoma Department of Health to act as designee for Low-Income Home Energy Assistance Block Grant certifications

2006-29 declaring an emergency due to extremely dry weather and lack of significant rainfall, temporarily suspend requirements for special permits for use of overweight/oversized vehicles under Title 47, licensing/operating authority required by Corporation Commission, licensing/registration as required by Tax Commission

2007-5 amending the AMBER plan for Oklahoma

2007-6 hiring freeze for 2007

2007-7 creating cabinet system

2007-8 establish the Governor's Elimination of Health Disparities Task Force

2007-11 establish the Governor's Task Force on Prevention of Underage Drinking

This Executive Order shall be distributed to all members of the Governor's Cabinet.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, this 6th day of April, 2007.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:
M. Susan Savage
Secretary of State

[OAR Docket #07-757; filed 4-12-07]

Executive Orders

1:2007-13.

EXECUTIVE ORDER 2007-13

I, Brad Henry, Governor of the State of Oklahoma, by the authority vested in me pursuant to Sections 1 and 2 of Article VI of the Oklahoma Constitution, hereby establish the Governor's Task Force on State Employee Compensation to establish a strategic direction for compensation for State executive branch employees.

The responsibilities and duties of the Task Force shall include, but not be limited to, the following:

1. Review and analyze existing data and reports relating to state employee direct (cash) compensation; analysis should include the use of relevant market studies.
2. Review state policies and practices relating to employee compensation;
3. Identify positions which pose critical recruitment and retention concerns for the state;
4. Review existing data and reports relating to state employee benefits, and determine the feasibility of performing a benefit value study of state employee benefits; and
5. Develop strategies to assure that critical recruitment and retention issues are addressed and that state employee pay is competitive with the external market on an on-going, long-term basis.

The Task Force shall consist of 9 members, to be appointed by, and to serve at the pleasure of, the Governor, as follows:

1. The Administrator of the Office of Personnel Management or designee;
2. The Director of the Office of State Finance or designee;
3. The Director of the Department of Human Services or designee;
4. The Director of the Department of Corrections or designee;
5. The Executive Director of the largest organization representing state employees in the State of Oklahoma or designee; and
6. Four senior level executives from the private sector, of which, one to be designated by the Governor to serve as chair of the Task Force.

The Task Force shall meet at such times and places as it deems appropriate. Members shall serve without compensation. Task Force members employed by a state agency shall be reimbursed travel expenses related to their service on the Task Force as authorized by State Law by their respective state agency. Remaining Task Force members shall be reimbursed travel expenses related to their service on the Task Force as authorized by state law by the Office of Personnel Management. Administrative support for the Task Force, including but not limited to personnel to insure the proper performance of the duties and responsibilities of the Task Force, shall be provided by the Office of Personnel Management and the Office of State Finance. All participating state agencies and entities shall provide for any administrative support requested by the Task Force.

The Task Force shall submit a final report to the Governor, President Pro Tempore, Co-President Pro Tempore, and Speaker of the House not later than January 1, 2008. The final report shall summarize the study and contain recommendations on compensation strategy designed to attract and retain the most qualified workforce for the State of Oklahoma.

This Executive Order shall be distributed to the Office of Personnel Management and the Office of State Finance, which shall cause the provisions of this order to be implemented.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 6th day of April, 2007.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:
M. Susan Savage
Secretary of State

[OAR Docket #07-758; filed 4-12-07]

1:2007-14.

EXECUTIVE ORDER 2007-14

I, Brad Henry, Governor of the State of Oklahoma, pursuant to the powers vested in me by the Oklahoma Statutes in 25 O.S. Section 82.1, hereby order the following dates be observed as holidays by the State of Oklahoma in 2008:

Tuesday	January 1, 2008	New Year's Day
Monday	January 21, 2008	Martin Luther King, Jr. Day
Monday	February 18, 2008	President's Day
Monday	May 26, 2008	Memorial Day
Friday	July 4, 2008	Independence Day
Monday	September 1, 2008	Labor Day
Tuesday	November 11, 2008	Veterans Day
Thursday & Friday	November 27 & 28, 2008	Thanksgiving
Thursday & Friday	December 25 & 26, 2008	Christmas

This Executive Order shall be forwarded to the Director of the Office of Personnel Management who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 6th day of April, 2007.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:
M. Susan Savage
Secretary of State

[OAR Docket #07-759; filed 4-12-07]
