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POLYGRAPH Examiners Board	560
Oklahoma Board of **PRIVATE** Vocational Schools	565
State Board for **PROPERTY** and Casualty Rates *(abolished 7-1-06; see also Title 365)*	570
State Board of Examiners of **PSYCHOLOGISTS**	575
Department of **CENTRAL** Services (*Formerly*: Office of **PUBLIC** Affairs)	580
PUBLIC Employees Relations Board	585
Oklahoma **PUBLIC** Employees Retirement System	590
Department of **PUBLIC** Safety	595
REAL Estate Appraiser Board	600
Oklahoma **REAL** Estate Commission	605
Board of Regents of **REDLANDS** Community College *(exempted 11-1-98)*	607
State **REGENTS** for Higher Education	610
State Department of **REHABILITATION** Services	612
Board of Regents of **ROGERS** State College *(exempted 11-1-98)*	615
Board of Regents of **ROSE** State College *(exempted 11-1-98)*	620
Oklahoma **SAVINGS** and Loan Board *(abolished 7-1-93)*	625
SCENIC Rivers Commission	630
Oklahoma Commission on **SCHOOL** and County Funds Management	635
Advisory Task Force on the Sale of **SCHOOL** Lands *(functions concluded 2-92)*	640
The Oklahoma School of **SCIENCE** and Mathematics	645
Oklahoma Center for the Advancement of **SCIENCE** and Technology	650
SECRETARY of State	655
Department of **SECURITIES**	660
Board of Regents of **SEMINOLE** State College *(exempted 11-1-98)*	665
SHEEP and Wool Commission	670
State Board of Licensed **SOCIAL** Workers	675
SOUTHERN Growth Policies Board	680
Oklahoma **SOYBEAN** Commission *(abolished 7-1-97)*	685
Board of Examiners for **SPEECH-LANGUAGE** Pathology and Audiology (*Formerly:* Board of Examiners for **SPEECH** Pathology and Audiology)	690
STATE Employee Charitable Contributions, Oversight Committee for (*Formerly*: **STATE** Agency Review Committee)	695
STATE Use Committee (*Formerly:* Committee on Purchases of Products and Services of the Severely **HANDICAPPED**) – *See* Title 304	
Oklahoma **STUDENT** Loan Authority	700
TASK Force 2000	705
Oklahoma **TAX** Commission	710
Oklahoma Commission for **TEACHER** Preparation	712
TEACHERS' Retirement System	715
State **TEXTBOOK** Committee	720
TOBACCO Settlement Endowment Trust Fund	723
Oklahoma **TOURISM** and Recreation Department	725
Department of **TRANSPORTATION**	730
Oklahoma **TRANSPORTATION** Authority (*Name changed to* Oklahoma **TURNPIKE** Authority *11-1-05*) - *See* Title 731	
Oklahoma **TURNPIKE** Authority (*Formerly:* Oklahoma **TRANSPORTATION** Authority AND Oklahoma **TURNPIKE** Authority) - *See* also Title 745	731
State **TREASURER**	735
Board of Regents of **TULSA** Community College *(exempted 11-1-98)*	740
Oklahoma **TURNPIKE** Authority (*Name changed to* Oklahoma **TRANSPORATION** Authority *11-1-99 - no rules enacted in this Title - See* Title 731)	745
Oklahoma **UNIFORM** Building Code Commission	748
Board of Trustees for the **UNIVERSITY** Center at Tulsa *(exempted 11-1-98)*	750
UNIVERSITY Hospitals Authority	752
UNIVERSITY Hospitals Trust	753
Board of Regents of the **UNIVERSITY** of Oklahoma *(exempted 11-1-98)*	755
Board of Regents of the **UNIVERSITY** of Science and Arts of Oklahoma *(exempted 11-1-98)*	760
Oklahoma **USED** Motor Vehicle and Parts Commission	765
Oklahoma Department of **VETERANS** Affairs	770
Board of **VETERINARY** Medical Examiners	775
Oklahoma Department of **CAREER** and Technology Education (*Formerly:* Oklahoma Department of **VOCATIONAL** and Technical Education)	780
Oklahoma **WATER** Resources Board	785
Board of Regents of **WESTERN** Oklahoma State College *(exempted 11-1-98)*	790
Oklahoma **WHEAT** Commission	795
Department of **WILDLIFE** Conservation	800
WILL Rogers and J.M. Davis Memorials Commission	805

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 160. DEPARTMENT OF CONSUMER CREDIT
CHAPTER 55. MORTGAGE BROKERS AND MORTGAGE LOAN ORIGINATORS

[OAR Docket #10-747]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 1. General Provisions
160:55-1-2 [AMENDED]
Subchapter 3. Licensing
160:55-3-1.1 [AMENDED]
160:55-3-1.2 [REVOKED]
160:55-3-1.3 [REVOKED]
160:55-3-1.4 [REVOKED]
160:55-3-3 [REVOKED]
160:55-3-3.1 [AMENDED]
160:55-3-4 [AMENDED]
160:55-3-8 [AMENDED]
160:55-3-9 [REVOKED]
160:55-3-9.1 [AMENDED]
160:55-3-10.1 [REVOKED]
160:55-3-12 [NEW]
160:55-3-13 [NEW]
Subchapter 5. Advisory Committee [REVOKED]
160:55-5-1 [REVOKED]
160:55-5-2 [REVOKED]
160:55-5-3 [REVOKED]
Subchapter 7. Records
160:55-7-1 [AMENDED]
Subchapter 9. Enforcement
160:55-9-10 [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-747; filed 5-4-10]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 10. SCHOOL ADMINISTRATION AND INSTRUCTIONAL SERVICES

[OAR Docket #10-776]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 13. Student Assessment
210:10-13-16. Student exceptions and exemptions related to graduation requirements for end-of-instruction exams [AMENDED]
SUBMITTED TO GOVERNOR:
March 29, 2009
SUBMITTED TO HOUSE:
March 29, 2009
SUBMITTED TO SENATE:
March 29, 2009

[OAR Docket #10-776; filed 5-6-10]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 15. CURRICULUM AND INSTRUCTION

[OAR Docket #10-777]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 3. Priority Academic Student Skills
Part 11. Social Studies
210:15-3-100. Oklahoma history for high school [AMENDED]
210:15-3-102. United States History 1850 to the present for high school [AMENDED]
210:15-3-104. World History for high school [AMENDED]
SUBMITTED TO GOVERNOR:
March 29, 2009
SUBMITTED TO HOUSE:
March 29, 2009
SUBMITTED TO SENATE:
March 29, 2009

[OAR Docket #10-777; filed 5-6-10]

TITLE 770. OKLAHOMA DEPARTMENT OF VETERANS AFFAIRS
CHAPTER 10. CENTER DIVISION PROGRAM

[OAR Docket #10-709]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 1. General Provisions

770:10-1-4 [AMENDED]
SUBMITTED TO GOVERNOR:
April 27, 2010
SUBMITTED TO HOUSE:
April 27, 2010
SUBMITTED TO SENATE:
April 27, 2010

[OAR Docket #10-709; filed 4-28-10]

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

[OAR Docket #10-742]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 1. General Provisions
780:10-1-1. [AMENDED]
Subchapter 3. State Technical Assistance, Supervision, and Services
780:10-3-1. [AMENDED]
780:10-3-2. [AMENDED]
780:10-3-3. [AMENDED]
780:10-3-8. [AMENDED]
Subchapter 5. Finance
780:10-5-4. [AMENDED]
Subchapter 7. Local Programs, Career Majors or Instructional Positions: 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, 2010
SUBMITTED TO HOUSE:
March 30, 2010
SUBMITTED TO SENATE:
March 30, 2010

[OAR Docket #10-742; filed 5-4-10]

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

[OAR Docket #10-743]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 3. Technology Centers Education
780:15-3-1. [AMENDED]
780:15-3-2. [AMENDED]
780:15-3-3. [AMENDED]
780:15-3-4. [AMENDED]
780:15-3-6. [AMENDED]
780:15-3-7. [AMENDED]
780:15-3-8. [AMENDED]
SUBMITTED TO GOVERNOR:
March 30, 2010
SUBMITTED TO HOUSE:
March 30, 2010
SUBMITTED TO SENATE:
March 30, 2010

[OAR Docket #10-743; filed 5-4-10]

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

[OAR Docket #10-744]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 1. General Provisions
780:20-1-1. [AMENDED]
780:20-1-2. [AMENDED]
Subchapter 3. Secondary, Full-Time and Short-Term Adult *Career*Tech Progams
780:20-3-2. [AMENDED]
780:20-3-3. [AMENDED]
780:20-3-4. [AMENDED]
780:20-3-5. [AMENDED]
SUBMITTED TO GOVERNOR:
March 30, 2010
SUBMITTED TO HOUSE:
March 30, 2010
SUBMITTED TO SENATE:
March 30, 2010

[OAR Docket #10-744; filed 5-4-10]

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 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #10-698]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 9. Individual Procedures
35:1-9-3 [AMENDED]
Subchapter 10. Requirements for Department Programs
35:1-10-1 through 35:1-10-5 [NEW]
Subchapter 11. Licensing Procedures
35:1-11-2 [AMENDED]
35:1-11-5 [AMENDED]
35:1-11-7 [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-698; filed 4-27-10]

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

[OAR Docket #10-699]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. Fee Schedules
35:2-3-12 [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-699; filed 4-27-10]

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

[OAR Docket #10-700]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. Fee Schedules
35:2-3-23 [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-700; filed 4-27-10]

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

[OAR Docket #10-701]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
35:13-1-6 [NEW]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-701; filed 4-27-10]

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

[OAR Docket #10-702]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. General Provisions
35:15-1-2 [AMENDED]
Subchapter 9. Livestock Dealers and Livestock Special Sales
Part 3. Livestock Special Sales
35:15-9-8 [AMENDED]
35:15-9-9 [AMENDED]
35:15-9-11 [REVOKED]
Subchapter 11. Importation of Livestock, Poultry, and Pets
Part 7. Livestock
35:15-11-20 [AMENDED]
Subchapter 13. Testing and Inspection for Disease and Release of Livestock at Auction Markets
35:15-13-1 [AMENDED]
35:15-13-3 [AMENDED]
35:15-13-5 through 35:15-13-7 [AMENDED]
Subchapter 15. Equine Infectious Anemia (EIA)
Part 5. Change of Ownership of Equidae
35:15-15-51 [AMENDED]
Part 7. Requirements for Approved Markets
35:15-15-71 [AMENDED]

35:15-15-72 [AMENDED]
Part 9. Equine Exhibitions
35:15-15-91 [AMENDED]
Part 11. Requirements for Equidae Entering Oklahoma
35:15-15-111 [AMENDED]
Subchapter 22. Swine Pseudorabies
Part 1. General Provisions
35:15-22-2 [AMENDED]
Part 3. Requirements for Swine Entering Oklahoma
35:15-22-31 [AMENDED]
35:15-22-32 [AMENDED]
Part 7. Requirements for Swine Exhibitions
35:15-22-71 [AMENDED]
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 34. Feral Swine
35:15-34-3 [AMENDED]

GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-702; filed 4-27-10]

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

[OAR Docket #10-703]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules

RULES:
Subchapter 17. Bovine and Bison Brucellosis
Part 1. Definitions
35:15-17-1 through 35:15-17-4 [AMENDED]
35:15-17-5 [REVOKED]
Part 3. Rules Adopted from USDA Uniform Methods and Rules (UM&R) for Brucellosis Eradication
35:15-17-32 [AMENDED]
35:15-17-33 [AMENDED]
35:15-17-35 through 35:15-17-44 [AMENDED]
35:15-17-46 [REVOKED]
35:15-17-47 through 35:15-17-54 [AMENDED]
35:15-17-55 [REVOKED]
35:15-17-56 [AMENDED]
35:15-17-57 [REVOKED]
Part 5. Brucella Vaccine
35:15-17-59 [AMENDED]
35:15-17-60 [AMENDED]
Part 7. Certified Brucellosis-Free Herds of Cattle or Bison
35:15-17-64 through 35:15-17-66 [AMENDED]
Part 11. Entry Permit and Retest Requirements
35:15-17-73 through 35:15-17-78 [AMENDED]
35:15-17-80 [AMENDED]
35:15-17-81 [AMENDED]
Part 13. Community Pastures
35:15-17-83 [AMENDED]
Part 15. Depopulation Payment
35:15-17-87 [AMENDED]
Part 17. Blood Typing
35:15-17-91 [AMENDED]

GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-703; filed 4-27-10]

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

[OAR Docket #10-704]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules

RULES:
Subchapter 38. Bovine Trichomoniasis
35:15-38-1 [AMENDED]
35:15-38-2 [AMENDED]
35:15-38-2.1 [NEW]
35:15-38-3 [AMENDED]
35:15-38-4 [REVOKED]

GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-704; filed 4-27-10]

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

[OAR Docket #10-705]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules

RULES:
Subchapter 40. Bovine Tuberculosis
Part 1. Definitions
35:15-40-1 [AMENDED]
Part 3. Rules Adopted from USDA Uniform Methods and Rules for Bovine Tuberculosis Eradication
35:15-40-31 through 35:15-40-43 [AMENDED]
35:15-40-45 through 35:15-40-49 [AMENDED]
35:15-40-49.1 [AMENDED]
35:15-40-50 [AMENDED]
Part 5. Herd Status Requirements
35:15-40-71 [AMENDED]
35:15-40-72 [AMENDED]
Part 7. Import Requirements

35:15-40-90 [AMENDED]
35:15-40-90.1 [AMENDED]
35:15-40-91 through 35:15-40-93 [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-705; filed 4-27-10]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 30. CONSUMER PROTECTION

[OAR Docket #10-706]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 17. Combined Pesticide
Part 2. Pesticide Rule Advisory Committee [NEW]
35:30-17-3.4 [NEW]
Part 9. Minimum Standards for Contracts and Keeping of Records
35:30-17-20 [AMENDED]
Part 15. Minimum Standards for Termite Work for Existing Structures
35:30-17-55 through 35:30-17-59 [AMENDED]
35:30-17-60 through 35:30-17-64 [REVOKED]
35:30-17-65 through 35:30-17-69 [AMENDED]
35:30-17-69.l [NEW]
35:30-17-69.2 [NEW]
Part 16. Minimum Standard for the Performance of Spot/Partial Treatments of Termite Work for Existing Structures (Spot Treatments) [REVOKED]
35:30-17-70 [REVOKED]
Part 22. Wood Infestation Reports
35:30-17-105 [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-706; filed 4-27-10]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 30. CONSUMER PROTECTION

[OAR Docket #10-707]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 36. Weed Free Hay Certification [NEW]
35:30-36-1 through 35:30-36-14 [NEW]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-707; filed 4-27-10]

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

[OAR Docket #10-708]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. Agriculture Environmental Permitting and AGPDES [NEW]
Part 1. General Provisions [NEW]
35:44-1-1 through 35:44-1-3 [NEW]
Part 2. The Process [NEW]
35:44-1-20 through 35:44-1-36 [NEW]
Part 3. Tiers and Time Lines [NEW]
35:44-1-37 through 35:44-1-41 [NEW]
Subchapter 3. ~~Concentrated Animal Feeding Operations~~ Discharge Permit Requirements
35:44-3-3 through 35:44-3-8 [NEW]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-708; filed 4-27-10]

TITLE 160. DEPARTMENT OF CONSUMER CREDIT CHAPTER 5. FEES

[OAR Docket #10-745]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
160:5-1-2 [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-745; filed 5-4-10]

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

[OAR Docket #10-746]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules

RULES:
Subchapter 9. Special Rules for Certain Home Mortgage Transactions
160:45-9-2 [AMENDED]
Appendix H. Closed-End Model Forms and Clauses [REVOKED]
Appendix H. Closed-End Model Forms and Clauses [NEW]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-746; filed 5-4-10]

TITLE 165. CORPORATION COMMISSION CHAPTER 30. MOTOR CARRIERS

[OAR Docket #10-686]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. General Provisions
165:30-1-1. Purpose [AMENDED]
165:30-1-2. Definitions [AMENDED]
Subchapter 3. Intrastate Motor Carriers
Part 1. Applying for a License
165:30-3-1. Obtaining a license [AMENDED]
165:30-3-3. License and certificate renewals [AMENDED]
Part 3. License Requirements
165:30-3-11. Insurance [AMENDED]
Part 5. Conducting Operations
165:30-3-32. Shipping documentation [AMENDED]
165:30-3-34. Minimum standards [AMENDED]
Part 9. Violations
165:30-3-71. Loading capacity - Safety compliance [AMENDED]
Subchapter 7. Procedural Rules
165:30-7-2. Notice [REVOKED]
165:30-7-5. Forms [AMENDED]
165:30-7-8. Review of Applicants for safety fitness [AMENDED]
165:30-7-11. USDOT number [AMENDED]
Subchapter 10. Interstate Motor Carriers
Part 1. Compliance
165:30-10-9. Minimum standards [NEW]
Part 3. Conducting Operations
165:30-10-13. Shipping documentation [AMENDED]
Subchapter 13. Intrastate Household Goods Certificates ~~or Permits~~
Part 1. ~~Applying for~~ Obtaining Authority
165:30-13-1. Reissuance of certificate [NEW]
165:30-13-2. Obtaining a household goods certificate ~~or permit~~ [AMENDED]
165:30-13-3. Temporary authority [REVOKED]
Part 3. Household Goods Certificate ~~or Permit~~ Requirements
165:30-13-11. Insurance [AMENDED]
165:30-13-12. Identification device [AMENDED]
165:30-13-13. Annual report [REVOKED]
165:30-13-14. COD shipments [REVOKED]
165:30-13-15. Markings [AMENDED]
165:30-13-16. Current address requirement [AMENDED]
165:30-13-17. Adoption of interstate tariff - filing of affidavit [REVOKED]
Part 5. Conducting Operations
165:30-13-20. Estimates [NEW]
165:30-13-22. Consumer protection information [NEW]
165:30-13-24. Valuation and liability [NEW]
165:30-13-26. Bill of Lading [NEW]
165:30-13-27. Blank or incomplete documents [NEW]
165:30-13-28. Additional services [NEW]
165:30-13-31. Compliance with laws and regulations [AMENDED]
165:30-13-32. Shipping documentation [REVOKED]
165:30-13-33. Records [AMENDED]
165:30-13-34. Minimum standards [AMENDED]
165:30-13-35. Credit [REVOKED]
165:30-13-36. Loss, damage and concealed claims [AMENDED]
165:30-13-37. Leasing of equipment [AMENDED]
Part 7. Name Changes ~~and Transfer~~
165:30-13-51. ~~Mergers and name~~ Name changes [AMENDED]
165:30-13-52. Transfer of certificate or permit [REVOKED]
165:30-13-53. Transfer upon death of holder of certificate or permit [REVOKED]
Part 9. Violations
165:30-13-71. Loading capacity-Safety compliance [AMENDED]
165:30-13-72. Leasing of authority [AMENDED]
165:30-13-73. Advertising [AMENDED]
165:30-13-74. Contempt complaint [AMENDED]
Part 11. Suspension or Cancellation of Authority
165:30-13-91. Voluntary suspension or discontinuance of service [REVOKED]
165:30-13-92. Involuntary suspension or revocation of a household goods certificate~~or permit~~ [AMENDED]
165:30-13-93. Reinstatement of certificate ~~or permit~~ [AMENDED]
165:30-13-94. Violations [AMENDED]
Subchapter 15. Intrastate Private Carriers
Part 5. Conducting Operations
165:30-15-14. ~~Legal possession of cargo~~ Shipping documentation [AMENDED]
Subchapter 19. Registration Pursuant to the International Registration Plan
165:30-19-19. Trip permits and hunters permits [AMENDED]
Subchapter 25. Harvest Permits [NEW]
165:30-25-1. Harvest permits [NEW]

GUBERNATORIAL APPROVAL:
April 16, 2010

[OAR Docket #10-686; filed 4-26-10]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 100. AIR POLLUTION CONTROL

[OAR Docket #10-716]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Appendix Q. Incorporation by Reference [REVOKED]
Appendix Q. Incorporation by Reference [NEW]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-716; filed 4-30-10]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 100. AIR POLLUTION CONTROL

[OAR Docket #10-717]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 17. Incinerators
Part 1. General Provisions
252:100-17-1. Purpose [AMENDED]
252:100-17-1.1. Reference to 40 CFR [AMENDED]
252:100-17-1.2. Terminology related to 40 CFR [REVOKED]
252:100-17-1.3. Incinerators and fuel-burning equipment or units [NEW]
Part 3. General Purpose Incinerators [AMENDED]
252:100-17-2. Applicability [AMENDED]
252:100-17-2.1. Exemptions [AMENDED]
252:100-17-2.2. Definitions [AMENDED]
252:100-17-4. Particulate matter [AMENDED]
252:100-17-5. Incinerator design and operation requirements [AMENDED]
252:100-17-5.1. Alternative incinerator design requirements [AMENDED]
252:100-17-7. Test methods [AMENDED]
Appendix A. Allowable Emissions for Incinerators with Capacities of 100 Lb/Hr or Greater [REVOKED]
Appendix A. Allowable Particulate Matter Emission Rate for Incinerators [NEW]
Appendix B. Allowable Emissions for Incinerators with Capacities less than 100 Lbs/Hr [REVOKED]

GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-717; filed 4-30-10]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 515. MANAGEMENT OF SOLID WASTE

[OAR Docket #10-714]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 39. Oklahoma E-Waste Recycling [NEW]
252:515-39-1. Purpose, authority and applicability [NEW]
252:515-39-2. Definitions [NEW]
252:515-39-3. Annual fees [NEW]
252:515-39-4. Records [NEW]
GUBERNATORIAL APPROVAL
April 14, 2010

[OAR Docket #10-714; filed 4-30-10]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 515. MANAGEMENT OF SOLID WASTE

[OAR Docket #10-715]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. General Provisions
252:515-1-2. Definitions [AMENDED]
252:515-1-8. Special considerations [AMENDED]
Subchapter 3. Permit Provisions and Applications
Part 1. General Provisions
252:515-3-2. Permit not required [AMENDED]
Part 3. Permit Applications and Modifications
252:515-3-42. Permits for transfer stations [NEW]
Subchapter 15. Methane Gas Monitoring and Control
252:515-15-1. Applicability~~, with exceptions~~ [AMENDED]
Subchapter 19. Operational Requirements
Part 3. Operational Requirements for All Disposal Facilities
252:515-19-31. Prohibited wastes [AMENDED]
Part 11. Additional Operational Requirements for Solid Waste Composting Facilities
252:515-19-111. Acceptable composting materials [AMENDED]
Subchapter 29. Exclusion of Prohibited Wastes
252:515-29-1. Applicability [AMENDED]

GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-715; filed 4-30-10]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 645. SEPTAGE PUMPERS AND ~~HAULERS~~ TRANSPORTERS

[OAR Docket #10-713]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Chapter 645. Septage Pumpers and ~~Haulers~~ Transporters [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-713; filed 4-30-10]

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

[OAR Docket #10-712]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. Introduction
252:690-1-3. Technical Acronyms [AMENDED]
252:690-1-4. Incorporation of USEPA regulations by reference [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-712; filed 4-30-10]

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

[OAR Docket #10-722]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-59. [AMENDED]
317:30-3-60. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-2. [AMENDED]
317:30-5-9. [AMENDED]
Part 3. Hospitals
317:30-5-42.17. [AMENDED]
(Reference APA WF # 09-28)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-722; filed 5-3-10]

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

[OAR Docket #10-723]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Individual Providers and Specialties
Part 4. Long Term Care Hospitals
317:30-5-65. [AMENDED]
Part 17. Medical Suppliers
317:30-5-211.17. [NEW]
(Reference APA WF # 09-32)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-723; filed 5-3-10]

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

[OAR Docket #10-724]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-20. [AMENDED]
Part 7. Certified Laboratories
317:30-5-100. [AMENDED]
(Reference APA WF # 09-52)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-724; filed 5-3-10]

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

[OAR Docket #10-728]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Individual Providers and Specialties
Part 65. Case Management Services for Over 21
317:30-5-585. [REVOKED]
317:30-5-586. [REVOKED]
Part 67. Behavioral Health Case Management Services ~~for Individuals Under 21 Years of Age~~
317:30-5-595. [AMENDED]
317:30-5-596. [AMENDED]
317:30-5-596.1. [AMENDED]
317:30-5-596.2. [REVOKED]
Part 97. Case Management Services for Under Age 18 at Risk of or in the Temporary Custody or Supervision of Office of Juvenile Affairs
317:30-5-972. [AMENDED]
Part 99. Case Management Services for Under Age 18 in Emergency, Temporary or Permanent Custody or Supervision of the Department of Human Services
317:30-5-992. [AMENDED]
(Reference APA WF # 09-64)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-728; filed 5-3-10]

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

[OAR Docket #10-729]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
317:30-5-764. [AMENDED]
Part 95. Agency Personal Care Services
317:30-5-950. [AMENDED]
(Reference APA WF # 09-65A)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-729; filed 5-3-10]

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

[OAR Docket #10-731]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
317:30-5-95.33 [AMENDED]
(Reference APA WF # 09-68)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-731; filed 5-3-10]

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

[OAR Docket #10-732]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-14. [AMENDED]
(Reference APA WF # 09-70)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-732; filed 5-3-10]

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

[OAR Docket #10-733]

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 51. Habilitation Services
317:30-5-482. [AMENDED]
(Reference APA WF # 09-72A)

GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-733; filed 5-3-10]

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

[OAR Docket #10-735]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-5. [AMENDED]
(Reference APA WF # 09-73)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-735; filed 5-3-10]

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

[OAR Docket #10-736]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-57. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 5. Pharmacies
317:30-5-72. [AMENDED]
(Reference APA WF # 09-74)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-736; filed 5-3-10]

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

[OAR Docket #10-737]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
317:30-5-211.10. [AMENDED]
317:30-5-211.12. [AMENDED]
317:30-5-211.15. [AMENDED]
317:30-5-218. [AMENDED]
Part 61. Home Health Agencies
317:30-5-547. [AMENDED]
(Reference APA WF # 09-76)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-737; filed 5-3-10]

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

[OAR Docket #10-738]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-62. [NEW]
317:30-3-63. [NEW]
(Reference APA WF # 09-77)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-738; filed 5-3-10]

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

[OAR Docket #10-719]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 17. ADvantage Waiver Services
317:35-17-12. [AMENDED]
317:35-17-17. through 317:35-17-18. [AMENDED]
317:35-17-20. [REVOKED]
317:35-17-21.1. [AMENDED]
(Reference APA WF # 09-02B)

GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-719; filed 5-3-10]

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

[OAR Docket #10-720]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationship
317:35-5-2. [AMENDED]
317:35-5-7. [AMENDED]
Part 5. Countable Income and Resources
317:35-5-43. [AMENDED]
317:35-5-44. [AMENDED]
Subchapter 10. ~~Medical Aid to Families with Dependent Children~~ Other Eligibility Factors for Families with Children and Pregnant Women
Part 5. Income
317:35-10-26. [AMENDED]
Subchapter 17. ADvantage Waiver Services
317:35-17-3. [AMENDED]
Subchapter 21. Breast and Cervical Cancer Treatment Program
317:35-21-11. [AMENDED]
(Reference APA WF # 09-20)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-720; filed 5-3-10]

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

[OAR Docket #10-721]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Eligibility and Countable Income
317:35-5-42. [AMENDED]
(Reference APA WF # 09-22)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-721; filed 5-3-10]

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

[OAR Docket #10-726]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Eligibility and Countable Income
Part 3. Non-Medical Eligibility Requirements
317:35-5-25. [AMENDED]
Subchapter 6. SoonerCare ~~Health Benefits~~ for Categorically Needy Pregnant Women and Families with Children
Part 7. Certification, Redetermination and Notification
317:35-6-60. [AMENDED]
317:35-6-61. [AMENDED]
(Reference APA WF # 09-55)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-726; filed 5-3-10]

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

[OAR Docket #10-727]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. General Provisions
317:35-1-2. [AMENDED]
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-6. [AMENDED]
317:35-5-6.1. [AMENDED]
Subchapter 6. SoonerCare ~~Health Benefits~~ for ~~Categorically Needy~~ Pregnant Women and Families with Children
Part 3. Application Procedures
317:35-6-15. [AMENDED]
Part 5. Determination of Eligibility for SoonerCare ~~Health Benefits~~ for Pregnant Women and Families with Children

317:35-6-38. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-6-62. [AMENDED]
317:35-6-63. [AMENDED]
317:35-6-64. [AMENDED]
317:35-6-64.1. [AMENDED]
Subchapter 7. Medical Services
Part 3. Application Procedures
317:35-7-15. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-7-60.1. [AMENDED]
317:35-7-63. [AMENDED]
317:35-7-64. [AMENDED]
317:35-7-65. [AMENDED]
Subchapter 22. Pregnancy Related Benefits Covered Under Title XXI
317:35-22-9. [AMENDED]
317:35-22-11. [AMENDED]
(Reference APA WF # 09-56)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-727; filed 5-3-10]

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

[OAR Docket #10-730]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 15. Personal Care Services
317:35-15-13.2. [AMENDED]
Subchapter 17. ADvantage Waiver Services
317:35-17-22. [AMENDED]
(Reference APA WF # 09-65B)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-730; filed 5-3-10]

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

[OAR Docket #10-734]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Member Services
Part 1. Agency Companion Services
317:40-5-3. [AMENDED]
317:40-5-8. [AMENDED]
317:40-5-11. [AMENDED]
Part 5. Specialized Foster Care
317:40-5-64. [AMENDED]
Part 9. Service Provisions
317:40-5-101. [AMENDED]
317:40-5-102. [AMENDED]
317:40-5-104. [AMENDED]
317:40-5-110. [AMENDED]
317:40-5-111. [AMENDED]
317:40-5-113. [AMENDED]
Part 11. Other Community Residential Supports
317:40-5-150. [AMENDED]
317:40-5-152. [AMENDED]
317:40-5-153. [AMENDED]
Subchapter 7. Employment Services Through Homes and Community- Based Services Waivers
317:40-7-12. [AMENDED]
317:40-7-21. [AMENDED]
(Reference APA WF # 09-72B)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-734; filed 5-3-10]

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

[OAR Docket #10-725]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 11. Insure Oklahoma/O-EPIC IP
Part 5. Insure Oklahoma/O-EPIC IP Member Eligibility
317:45-11-20. [AMENDED]
317:45-11-27. [AMENDED]
(Reference APA WF # 09-53)
GUBERNATORIAL APPROVAL:
April 21, 2010

[OAR Docket #10-725; filed 5-3-10]

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

[OAR Docket #10-765]

RULEMAKING ACTION:
Gubernatorial approval
RULES:
Subchapter 1. Human Resources Management Division
Part 1. General Provisions
340:2-1-1 through 340:2-1-2 [AMENDED]
340:2-1-6 [AMENDED]
Part 3. Internal Human Resources
340:2-1-25 [REVOKED]
340:2-1-26 through 340:2-1-29 [AMENDED]
Part 5. Administrative Procedures
340:2-1-56 through 340:2-1-57 [AMENDED]
Part 7. Recruitment, Selection, and Placement Policy and Procedures
340:2-1-75 through 340:2-1-80 [AMENDED]
340:2-1-82 through 340:2-1-85 [AMENDED]
340:2-1-86 [REVOKED]
340:2-1-88 [AMENDED]
340:2-1-93 [AMENDED]
(Reference APA WF 10-01)
GUBERNATORIAL APPROVAL:
April 28, 2010

[OAR Docket #10-765; filed 5-5-10]

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

[OAR Docket #10-766]

RULEMAKING ACTION:
Gubernatorial approval
RULES:
Subchapter 13. Contracts and Purchasing Unit
Part 1. Contracts and Purchasing Unit [REVOKED]
340:2-13-10 through 340:2-13-14.11 [REVOKED]
340:2-13-14.13 through 340:2-13-14.15 [REVOKED]
340:2-13-14.17 through 340:2-13-14.18 [REVOKED]
Part 5. Products and Nonprofessional Services [REVOKED]
340:2-13-47 through 340:2-13-48 [REVOKED]
340:2-13-50 [REVOKED]
340:2-13-53 through 340:2-13-59 [REVOKED]
Part 7. Contracts and Purchasing [NEW]
340:2-13-75 through 340:2-13-104 [NEW]
Appendix K. Professional Service Contract Affidavit Form [REVOKED]
(Reference APA WF 10-04)
GUBERNATORIAL APPROVAL:
April 28, 2010

[OAR Docket #10-766; filed 5-5-10]

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

[OAR Docket #10-767]

RULEMAKING ACTION:
Gubernatorial approval
RULES:
Subchapter 3. Conditions of Eligibility - Income
Part 3. Income
340:10-3-40 [AMENDED]
Subchapter 10. Conditions of Eligibility - Deprivation
340:10-10-5 [AMENDED]
340:10-10-7 [AMENDED]
Subchapter 15. Conditions of Eligibility - Citizenship and Alienage
340:10-15-1 [AMENDED]
(Reference APA WF 09-12 and WF 10-03)
GUBERNATORIAL APPROVAL:
April 28, 2010

[OAR Docket #10-767; filed 5-5-10]

TITLE 550. OKLAHOMA POLICE PENSION AND RETIREMENT SYSTEM
CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #10-760]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. Organization of Board
550:1-3-3 [AMENDED]
GUBERNATORIAL APPROVAL:
April 26, 2010

[OAR Docket #10-760; filed 5-5-10]

TITLE 550. OKLAHOMA POLICE PENSION AND RETIREMENT SYSTEM CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #10-761]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 5. Petition Procedures
550:1-5-2 [AMENDED]
GUBERNATORIAL APPROVAL:
April 26, 2010

[OAR Docket #10-761; filed 5-5-10]

TITLE 550. OKLAHOMA POLICE PENSION AND RETIREMENT SYSTEM CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #10-762]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 7. Collections and Disbursements
550:1-7-1 [AMENDED]
GUBERNATORIAL APPROVAL:
April 26, 2010

[OAR Docket #10-762; filed 5-5-10]

TITLE 550. OKLAHOMA POLICE PENSION AND RETIREMENT SYSTEM CHAPTER 15. OKLAHOMA POLICE DEFFERRED OPTION PLAN

[OAR Docket #10-763]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
550:15-1-2 [AMENDED]
GUBERNATORIAL APPROVAL:
April 26, 2010

[OAR Docket #10-763; filed 5-5-10]

TITLE 550. OKLAHOMA POLICE PENSION AND RETIREMENT SYSTEM CHAPTER 30. PERIODS OF ABSENCE FOR WHICH A MEMBER IS NOT RECEIVING COMPENSATION

[OAR Docket #10-764]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Chapter 30. Periods of Absence for Which a Member Is Not Receiving Compensation[NEW]
GUBERNATORIAL APPROVAL:
April 26, 2010

[OAR Docket #10-764; filed 5-5-10]

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

[OAR Docket #10-690]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 2. General Provisions
580:15-2-1. through 580:15-2-9. [AMENDED]
580:15-2-11. [AMENDED]
580:15-2-12. [NEW]
Subchapter 4. Supplier Provisions
580:15-4-1. [REVOKED]
580:15-4-2. [AMENDED]
580:15-4-4. through 580:15-4-7. [AMENDED]
580:15-4-9. [AMENDED]
580:15-4-11.1. [NEW]
580:15-4-13. through 580:15-4-15. [AMENDED]
580:15-4-16. [REVOKED]
580:15-4-18. [AMENDED]
580:15-4-19. [AMENDED]
Subchapter 6. State Agency Provisions
580:15-6-1. [REVOKED]
580:15-6-2. [AMENDED]
580:15-6-3. [AMENDED]
580:15-6-4. [REVOKED]
580:15-6-5. [AMENDED]
580:15-6-6. [AMENDED]
580:15-6-6.1. [NEW]
580:15-6-6.2. [NEW]
580:15-6-10. [AMENDED]
580:15-6-14. [AMENDED]
580:15-6-15. [AMENDED]
580:15-6-18. through 580:15-6-21. [AMENDED]

GUBERNATORIAL APPROVAL:
April 16, 2010

[OAR Docket #10-690; filed 4-27-10]

TITLE 690. BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
CHAPTER 10. LICENSURE AND FEES

[OAR Docket #10-697]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. Licensure of Speech-Language Pathologists and Audiologists
690:10-3-1. [AMENDED]
690:10-3-3. [AMENDED]
690:10-3-4. [AMENDED]
690:10-3-5. [AMENDED]
690:10-3-6. [AMENDED]
690:10-3-8. [AMENDED]
Subchapter 5. Licensure of Speech-Language Pathology Clinical Experience Interns
690:10-5-1. [AMENDED]
690:10-5-6. [AMENDED]
Subchapter 7. ~~Authorlzatlon of Assistants~~ Licensure of Speech-Language Pathology Assistants and Audiology Assistants
690:10-7-1. [AMENDED]
690:10-7-3. [AMENDED]
690:10-7-4. [AMENDED]
690:10-7-5. [AMENDED]
690:10-7-6. [AMENDED]
690:10-7-7. [AMENDED]
690:10-7-9. [NEW]
690:10-7-10. [NEW]
690:10-7-11. [NEW]
Subchapter 9. Fees
690:10-9-1. [AMENDED]
690:10-9-2. [AMENDED]
690:10-9-5. [AMENDED]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-697; filed 4-27-10]

TITLE 785. OKLAHOMA WATER RESOURCES BOARD
CHAPTER 45. OKLAHOMA'S WATER QUALITY STANDARDS

[OAR Docket #10-710]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. General Provisions
785:45-1-2. Definitions [AMENDED]
Subchapter 5. Surface Water Quality Standards
Part 1. General Provisions
785:45-5-3. Beneficial uses: default designations [AMENDED]
Part 3. Beneficial Uses and Criteria to Protect Uses
785:45-5-19. Aesthetics [AMENDED]
Appendix E. Requirements for Development of Site-Specific Criteria for Certain Parameters [REVOKED]
Appendix E. Requirements for Development of Site-Specific Criteria for Certain Parameters [NEW]
Appendix G. Numerical Criteria to Protect Beneficial Uses [REVOKED]
Appendix G. Numerical Criteria to Protect Beneficial Uses [NEW]
Appendix H. Beneficial Use Designations for Certain Limited Areas of Groundwater [REVOKED]
Appendix H. Beneficial Use Designations for Certain Limited Areas of Groundwater [NEW]
GUBERNATORIAL APPROVAL:
April 14, 2010

[OAR Docket #10-710; filed 4-29-10]

TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION
CHAPTER 1. OPERATIONS AND PROCEDURES

[OAR Docket #10-691]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 11. Publications
800:1-11-1. Charges for workshops, publications and other material [AMENDED]
Subchapter 19. Aquatic Education Rules
800:1-19-1. Instructors [AMENDED]
GUBERNATORIAL APPROVAL:
March 25, 2010

[OAR Docket #10-691; filed 4-27-10]

TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION
CHAPTER 10. SPORT FISHING RULES

[OAR Docket #10-692]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. Harvest and Possession Limits
800:10-1-4. Size limits on fish [AMENDED]
800:10-1-5. Bag limits on fish [AMENDED]
Subchapter 3. Methods of Taking
800:10-3-5. Use of bow and arrow, grabhooks, gigs, spears, and spearguns, snagging, noodling and netting [AMENDED]
Subchapter 5. Area Restriction and Special Fees
800:10-5-4. Fish sanctuaries [AMENDED]
GUBERNATORIAL APPROVAL:
March 25, 2010

[OAR Docket #10-692; filed 4-27-10]

TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION
CHAPTER 15. COMMERCIAL HARVEST RULES; AQUATIC SPECIES

[OAR Docket #10-693]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 13. Fishing Guide License [NEW]
800:15-13-1. Purpose [NEW]
800:15-13-2. License and fee requirements [NEW]
GUBERNATORIAL APPROVAL:
March 25, 2010

[OAR Docket #10-693; filed 4-27-10]

TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION
CHAPTER 20. RESTRICTION ON AQUATIC SPECIES INTRODUCTIONS

[OAR Docket #10-694]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 1. Restricted Exotic Fish
800:20-1-2. List of restricted exotic species [AMENDED]
GUBERNATORIAL APPROVAL:
March 25, 2010

[OAR Docket #10-694; filed 4-27-10]

TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION
CHAPTER 25. WILDLIFE RULES

[OAR Docket #10-695]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules
RULES:
Subchapter 3. Hunting on Corps of Engineers Land
800:25-3-2. Areas open to shotgun with pellets and bow and arrow only [AMENDED]
800:25-3-3. Areas open to archery only [AMENDED]
Subchapter 7. General Hunting Seasons
Part 1. General Provisions
800:25-7-3. General provisions [AMENDED]
Part 5. Upland Game
800:25-7-19. Wild turkey - general provisions [AMENDED]
Part 13. Deer
800:25-7-50. General provisions for deer [AMENDED]
800:25-7-55. Deer-Youth Gun Season [AMENDED]
Part 14. Elk
800:25-7-57. Dates, open areas, bag limit and hunting hours [AMENDED]
Part 15. Furbearers
800:25-7-60. Dates and legal furbearers [AMENDED]
Part 19. Season on Areas Owned or Managed by the Oklahoma Department of Wildlife Conservation and the U.S. Fish and Wildlife Service
800:25-7-87.1. Candy Creek WMA [NEW]
800:25-7-92. Chickasaw NRA [AMENDED]
800:25-7-94.4. Deep Fork NWR [AMENDED]
800:25-7-105.5. Hackberry Flat WMA [AMENDED]
800:25-7-140. Sandy Sanders WMA [AMENDED]
GUBERNATORIAL APPROVAL:
March 25, 2010

[OAR Docket #10-695; filed 4-27-10]

TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION
CHAPTER 30. DEPARTMENT OF WILDLIFE LANDS MANAGEMENT

[OAR Docket #10-696]

RULEMAKING ACTION:
Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Use of Department Managed Lands

800:30-1-4. Camping [AMENDED]

800:30-1-8. Language, disorderly assemblage, noise or other disruptive acts [AMENDED]

GUBERNATORIAL APPROVAL:

March 25, 2010

[OAR Docket #10-696; filed 4-27-10]

Errors in Published Documents

If an agency discovers an error in a document after its publication in the *Register*, the agency may publish in the *Register* a notice of such error, but only if the error meets criteria set forth in OAC 655:10-7-35.

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

[OAR Docket #10-759]

ACTION:

Notice of error in published document

DOCUMENT CORRECTED:

Document type:

Statement of Submission for Gubernatorial and Legislative Review

Rules:

Chapter 10. Oil and Gas Conservation [AMENDED]

Register publication:

27 Ok Reg 869

Docket number:

10-478

CORRECTIONS:

Information cited in the Statement of Submission for Gubernatorial and Legislative Review under the heading RULES was incorrect. It should read as follows:

Chapter 10. Oil and Gas Conservation [AMENDED]

[OAR Docket #10-759; filed 5-5-10]

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 48. WILDLIFE SERVICES

[OAR Docket #10-741]

RULEMAKING ACTION:
EMERGENCY adoption
RULES:
Subchapter 1. General Provisions [RESERVED]
Subchapter 3. Aerial Hunting [NEW]
35:48-3-1. Definitions [NEW]
35:48-3-2. Permit required [NEW]
35:48-3-3. Application requirements [NEW]
35:48-3-4. Reporting requirements [NEW]
35:48-3-5. Indigenous species [NEW]
AUTHORITY:
State Board of Agriculture; 2 O.S. §§ 2-4; Engrossed House Bill 2158, Section 3 (uncodified)
DATES:
Adoption:
February 17, 2010
Approved by Governor:
February 26, 2010
Effective:
Immediately upon Governor's approval
Expiration:
Effective through July 14, 2011 unless superseded by another rule or disapproved by the Legislature
SUPERSEDED EMERGENCY ACTIONS:
N/A
INCORPORATIONS BY REFERENCE:
N/A
FINDING OF EMERGENCY:
This emergency rule is necessary due to a compelling public interest. House Bill 2158 of the 2009 Legislature contains an uncodified section 3 requiring the Department to promulgate emergency rules to implement section 1 of the act.
ANALYSIS:
The purpose of the proposed rules is to create rules for the issuance of permits to those individuals with an Oklahoma Department of Wildlife Conservation big game commercial hunting area license for aerial hunting. The emergency rules are required to address fees, application procedures, and other rules necessary to administer the act. A permanent rulemaking is also being conducted for the same rules.
CONTACT PERSON:
Teena Gunter (405) 522-4576

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 1. GENERAL PROVISIONS [RESERVED]

SUBCHAPTER 3. AERIAL HUNTING

35:48-3-1. Definitions

The following terms as used in this subchapter shall mean:

"Depredating animal" means feral hogs, coyotes, and crossbreeds between coyotes and dogs;

"Management of depredating animals" means to manage by counting, photographing, relocating, capturing, or hunting by the use of aircraft; and

"Aircraft" means non-fixed wing rotary aircraft only, so that lifting surfaces rotate on a vertical axis to generate lift and does not have a rear propeller that generates forward thrust. All aircraft shall be registered with the Federal Aviation Administration and shall be rated at a minimum of 200 horsepower with dual controls removed.

35:48-3-2. Permit required

(a) The Oklahoma Department of Agriculture, Food, and Forestry is may issue an aerial hunting permit to any person who holds a big game commercial hunting area license issued pursuant to Section 4-106 of Title 29 of the Oklahoma Statutes to engage in the management of depredating animals by use of aircraft only on land listed in the commercial hunting area license.

(b) The aerial hunting permit may be issued without limitation by statewide season regulations or bag limits.

(c) The aerial hunting permit shall be carried in the aircraft when performing management of depredating animals by the use of aircraft.

35:48-3-3. Application requirements

(a) Applications for an aerial hunting permit shall be submitted to the Department.

(b) The Department may issue an aerial hunting permit if it finds that it will aid in the management of depredating animals.

(c) The Department may deny an aerial hunting permit if it finds that it will have a deleterious effect on indigenous species.

(d) The aerial hunting permit shall include, but is not limited to, the following information:

(1) The name and address of each authorized person;
(2) A description of the animals and number of animals authorized to be taken;
(3) A description of the area from which the animals are authorized to be taken; and
(4) The issue date and expiration date of the aerial hunting permit.

(e) An aerial hunting permit to manage depredating animals issued pursuant to this section shall be valid for a period of one (1) year from the date of issuance.

(f) An aerial hunting permit shall not be bartered or transferred to any other person.

(g) Aerial hunting permits may be renewed by filing an application for renewal with the Department at least thirty (30) days prior to the expiration date.

(h) The permittee shall carry a minimum of $300,000 in liability insurance and shall provide proof of liability insurance at the time of application and renewal.

(i) The only firearm designated for aerial hunting is a shotgun firing pellet ammunition.

(j) Aerial hunting shall occur during daylight hours only.

35:48-3-4. Reporting requirements

(a) The pilot of an aircraft used for the management of depredating animals shall:
(1) Maintain a daily flight log and report.
(2) Make the daily flight log current and available for inspection by authorized agents of the Oklahoma Department of Agriculture, Food, and Forestry employees at reasonable times.
(3) Comply with all Federal Aviation Administration (FAA) regulations for the specific type of aircraft.
(4) Hold a current pilot's certificate from the FAA.
(5) Maintain a minimum current FAA class II medical.
(6) Complete a minimum of 250 hours low level time for the aircraft type.

(b) The permit application and any required reporting may be transmitted to the Department by email with supporting written documentation.

(c) Copies of the required flight log and report shall be sent to the Department within thirty (30) days of flight activity.

(d) A permit holder shall notify the Department in writing of the date, time, and area where management of depredating animals by use of an aircraft will occur no less than twenty-four (24) hours prior to the flight.

(e) The holder of a permit to manage depredating animals shall, within thirty (30) days following the end of a calendar quarter or upon termination of a permit, file with the Department a report showing:
(1) The name, address, and permit number of the permit holder;
(2) The name and address of the pilot and any other person participating in the flights;
(3) The number and description of the depredating animals managed under the permit;
(4) The types of depredating animals authorized to be managed under the permit;
(5) Dates and times of authorized flights; and
(6) Any other information requested by the Department.

35:48-3-5. Indigenous species

The Commissioner of Agriculture shall appoint a Department representative to meet annually with representatives designated by the Director of the Oklahoma Department of Wildlife Conservation to determine if private aircraft activities have a "deleterious effect on indigenous species."

[OAR Docket #10-741; filed 5-3-10]

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

[OAR Docket #10-739]

RULEMAKING ACTION:
EMERGENCY adoption
RULES:
Subchapter 5. Individual Providers and Specialties
Part 83. ~~Residential Behavior Management Services in Foster Care Settings~~Outpatient Behavioral Health Services in Therapeutic Foster Care Homes
317:30-5-740. [AMENDED]
317:30-5-740.1. [AMENDED]
317:30-5-741. [AMENDED]
317:30-5-742. [AMENDED]
317:30-5-742.1. [AMENDED]
317:30-5-742.2. [AMENDED]
317:30-5-743. [REVOKED]
317:30-5-743.1. [AMENDED]
317:30-5-744. [AMENDED]
317:30-5-745. [AMENDED]
(Reference APA WF # 10-02)
AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes
DATES:
Adoption:
March 11, 2010
Approved by Governor:
April 21, 2010
Effective:
Immediately upon Governor's approval
Expiration:
Effective through July 14, 2011, unless superseded by another rule or disapproved by the Legislature
SUPERSEDED EMERGENCY ACTIONS:
N/A
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 amend policy to change the reimbursement methodology for outpatient behavioral health services in Therapeutic Foster Care settings to comply with directives from the Centers for Medicare and Medicaid Services (CMS).
ANALYSIS:
Rules are revised to change the reimbursement methodology for outpatient behavioral health services provided in Therapeutic Foster Care settings from an all inclusive per diem payment to fee-for-service. The requirement of "unbundling" per diem rates has been an ongoing trend for the Centers for Medicare and Medicaid Services (CMS). This change will more closely align

our reimbursement with CMS preferences and requirements. Rules are also revised to update terminology, provider requirements and coverage guidelines.
CONTACT PERSON:
Tywanda Cox at (405)522-7153

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 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 83. ~~RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS~~ OUTPATIENT BEHAVIORAL HEALTH SERVICES IN THERAPEUTIC FOSTER CARE HOMES

317:30-5-740. Eligible providers

~~(a) Eligible Residential Behavior Management Service (RBMS) agencies must:~~

~~(1) have a current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency, and~~

~~(2) have a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, and~~

~~(3) have a contract with the Oklahoma Health Care Authority.~~

~~(b) Effective July 1, 2002, an eligible RBMS must:~~

~~(1) have a current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency, and~~

~~(2) have a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, and~~

~~(3) have a contract with the Oklahoma Health Care Authority, and~~

~~(4) have current accreditation status appropriate to provide behavioral management services in a foster care setting from:~~

~~(A) Joint Commission on Accreditation of Health Care Organization (JCAHO), or~~

~~(B) the Rehabilitation Accreditation Commission (CARF), or~~

~~(C) the Council on Accreditation (COA), or~~

~~(D) the American Osteopathic Association (AOA).~~

~~(c) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers for behavior management therapies in a foster care setting, providers must have the following qualifications:~~

~~(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor, or under Board approved supervision to be licensed in one of the above stated areas; or~~

~~(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided AND~~

~~(3) demonstrate a general professional or educational background in the following areas:~~

~~(A) case management, assessment and treatment planning;~~

~~(B) treatment of victims of physical, emotional, and sexual abuse;~~

~~(C) treatment of children with attachment disorders;~~

~~(D) treatment of children with hyperactivity or attention deficit disorders;~~

~~(E) treatment methodologies for emotionally disturbed children and youth;~~

~~(F) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(G) treatment of children and families with substance abuse and chemical dependency disorders;~~

~~(H) anger management;~~

~~(I) crisis intervention; and~~

~~(J) trauma informed methodology.~~

~~(d) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for Group Rehabilitative Treatment Services in a foster care setting facilitated by their staff, providers must have the following qualifications:~~

~~(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, alcohol and drug counselor, or behavioral practitioner, or under Board approved supervision to be licensed in one of the above stated areas; or~~

~~(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided; or~~

~~(3) have a baccalaureate degree in a behavioral health field, a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and have access to weekly consultation with a licensed mental health professional.~~

~~(e) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for Individual Rehabilitative Treatment Services for redevelopment therapy in a foster care setting facilitated by their staff, providers must have the following qualifications:~~

~~(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, alcohol and drug counselor, or behavioral~~

~~practitioner, or under Board approved supervision to be licensed in one of the above stated areas; or~~

~~(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided; or~~

~~(3) have a baccalaureate degree in a behavioral health field, a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and have access to weekly consultation with a licensed mental health professional; or~~

~~(4) be classified by the RBMS agency as a Treatment Parent Specialist under the supervision of a licensed, or under supervision for licensure, behavioral health professional of the RBMS.~~

~~(A) The Treatment Parent Specialist must meet the following criteria:~~

~~(i) have a high school diploma or equivalent;~~

~~(ii) be employed by the RBMS as a foster parent complete with OSBI and OKDHS background screening;~~

~~(iii) completion of therapeutic foster parent training outlined in 317:30-5-740.1(a);~~

~~(iv) have a minimum of twice monthly face to face supervision with the licensed, or under supervision for licensure, professional;~~

~~(v) have weekly contact with the RBMS professional staff; and~~

~~(vi) complete required annual trainings.~~

(a) **Definitions.** The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

(1) **Therapeutic foster care (TFC) agencies.** A foster care agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Therapeutic foster care settings are foster family homes.

(2) **Therapeutic foster care homes.** Agency-supervised private family homes in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family living environment for children and adolescents with significant emotional or behavioral problems who require a higher level of care than is found in a conventional foster home but do not require placement in a more restrictive setting. Therapeutic foster care homes are considered the least restrictive out-of-home placement for children with severe emotional disorders.

(b) **TFC Agency Requirements.** Eligible TFC agencies must have:

(1) current certification from the Oklahoma Department of Human services (OKDHS) as a child placing agency;

(2) a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, or OJA;

(3) a contract with the Oklahoma Health Care Authority; and

(4) a current accreditation status appropriate to provide outpatient behavioral health services in a foster care setting from:

(A) The Joint Commission formerly the Joint Commission on Accreditation (JCAHO), or

(B) the Rehabilitation Accreditation Commission (CARF), or

(C) the Council on Accreditation (COA), or

(D) the American Osteopathic Association (AOA).

317:30-5-740.1. ~~Eligible provider contracting requirements~~ Provider qualifications and requirements

~~(a) Eligible agency providers that are defined in section OAC 317:30-5-740 shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:~~

~~(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;~~

~~(2) treatment of victims of physical, emotional, and sexual abuse;~~

~~(3) treatment of children with attachment disorders;~~

~~(4) treatment of children with hyperactive or attention deficit disorders;~~

~~(5) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(6) treatment of children and families with substance abuse and chemical dependency disorders;~~

~~(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;~~

~~(8) anger management;~~

~~(9) inpatient authorization procedures;~~

~~(10) crisis intervention;~~

~~(11) grief and loss issues for children in foster care;~~

~~(12) the significance/value of birth families to children receiving services in residential behavior management services in a foster care setting; and~~

~~(13) trauma informed methodology.~~

~~(b) Eligible agency providers defined at OAC 317:30-5-740 must provide staff with access to professional psychiatric and/or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment.~~

(a) **Therapeutic foster care model.** Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:

(1) **Behavioral Health Rehabilitation Specialist (BHRS).** A bachelors level team member that may provider support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (c), the BHRS must have:

(A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and

(B) have access to weekly consultation with a licensed behavioral health professional.

(2) **Licensed Behavioral Health Professional (LBHP).** A masters level professional that provides treatment and supervision for the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a), the LBHP in a TFC setting must demonstrate a general processional or educational background in the following areas:

(A) case management, assessment and treatment planning;

(B) treatment of victims of physical, emotional, and sexual abuse;

(C) treatment of children with attachment disorders;

(D) treatment of children with hyperactivity or attention deficit disorders;

(E) treatment methodologies for emotionally disturbed children and youth;

(F) normal childhood development and the effect of abuse and/or neglect on childhood development;

(G) anger management;

(H) crisis intervention; and

(I) trauma informed methodology.

(3) **Licensed Psychiatrist and/or psychologist.** TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.

(4) **Treatment Parent Specialist (TPS).** The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:

(A) have a high school diploma or equivalent;

(B) be employed by the foster care agency as a foster parent complete with OSBI and OKDHS background screening;

(C) completion of therapeutic foster parent training outlined in this section;

(D) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the child's family therapy;

(E) have weekly contact with the foster care agency professional staff; and

(F) complete required annual trainings.

(c) **Agency assurances.** The TFC agency must ensure that each individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for direct enrollment must have a contract on file with the Oklahoma Health Care Authority

(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;

(2) treatment of victims of physical, emotional, and sexual abuse;

(3) treatment of children with attachment disorders;

(4) treatment of children with hyperactive or attention deficit disorders;

(5) normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) treatment of children and families with substance abuse and chemical dependency disorders;

(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) anger management;

(9) inpatient authorization procedures;

(10) crisis intervention;

(11) grief and loss issues for children in foster care;

(12) the significance/value of birth families to children receiving outpatient behavioral health services in a foster care setting; and

(13) trauma informed methodology.

317:30-5-741. Coverage by category

(a) **Adults.** ~~Residential Behavior Management~~ Outpatient Behavioral Health Services in Therapeutic Foster settings are not covered for adults.

(b) **Children.** ~~Residential Behavior Management~~ Outpatient behavioral health ~~Services~~ services are ~~provided in residential foster care programs~~ authorized in therapeutic foster care settings for certain children and youth ~~authorized~~ by the designated agent of the Oklahoma Health Care Authority. The children and youth authorized ~~designated~~ for services in this ~~program~~ setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this ~~program~~ setting. The medical necessity criteria are continually met for

initial requests for services and all subsequent requests for services/ extensions. Medical necessity criteria ~~are as follows:~~ is delineated in the OHCA Behavioral Health Provider Manual.

~~(1) Any DSM-IV-AXIS-I primary diagnosis, with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Mental Health Professional as defined in OAC 317:30-5-240(c) within the 30 day period resulting in a DSM-IV-AXIS-I primary diagnosis with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.~~

~~(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.~~

~~(3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.~~

~~(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.~~

~~(5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.~~

~~(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.~~

317:30-5-742. Description of services

~~(a) Behavior management services mean all the services listed in (1)-(8) of this subsection as provided in the individual plan of care. Each of the service requirements has special duration and frequency requirements as set out in OAC 317:30-5-742.2.~~

~~(1) Individual therapy;~~

~~(2) Substance abuse/chemical dependency education, prevention, and therapy;~~

~~(3) Group rehabilitative treatment;~~

~~(4) Family therapy;~~

~~(5) Basic living skills redevelopment;~~

~~(6) Social skills redevelopment;~~

~~(7) Crisis/behavior management redirection; and~~

~~(8) Discharge planning.~~

~~(b) Behavior management services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Behavior management services are considered an ancillary component of inpatient hospital care and residential treatment services provided in a less restrictive setting and as a less costly alternative to inpatient psychiatric hospital services and other residential treatment services.~~

~~(c) Behavioral Management Services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(1).~~

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting.

(b) Outpatient behavioral health services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(b)(1). Treatment services in a therapeutic foster care setting may include an array of services listed in (1) - (6) of this subsection as provided in the individual plan of care. Services include, but may not be limited to:

(1) Individual, family and group therapy;

(2) Substance abuse/chemical dependency education, prevention, and therapy;

(3) Psychosocial rehabilitation and support services;

(4) Behavior management

(5) Crisis intervention; and

(6) Case Management.

317:30-5-742.1. ~~Residential behavior management reimbursement~~ Reimbursement

~~(a) All Residential Behavioral Management Services must be prior authorized by the designated agent of the Oklahoma Health Care Authority before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized.~~

~~(b) The Oklahoma Health Care Authority will not reimburse for the services defined in OAC 317:30-5-742 for more than two children in a home at any one time unless additional cases are specifically authorized by the Oklahoma Department of Human Services, Division of Children and Family Services or Oklahoma Office of Juvenile Affairs.~~

~~(c) A child who is eligible for the services defined in OAC 317:30-5-742 is not to receive any other outpatient behavioral health services defined by OHCA unless prior authorized by OHCA or its designated agent. For example, separate individual therapy for a child eligible for Residential Behavioral Management Services will not generally be authorized because this service is part of the bundled service provided by a Residential Behavioral Management provider. If additional outpatient services are authorized by OHCA or its designated agent, the service provider may not be the provider of the Residential Behavioral Management Services.~~

~~(d) OHCA will not reimburse an eligible service provider for units of service that are not authorized before the service is delivered.~~

~~(e) Initial requests for residential foster care and the first extension request will be approved for a maximum of six months. All subsequent requests for services/extensions will be for a maximum time period not to exceed three months.~~

~~(f) No reimbursement is made for a service for a member without a written individual plan of care for each member as described in OAC 317:30-5-742.2(1). Each individual plan of care must contain all of the services required in OAC 317:30-5-742(a).~~

Services provided to a member without a written individual plan of care as described in OAC 317:30-5-742.2(b)(1) will not be reimbursed.

317:30-5-742.2. ~~Required Residential Behavior Management Services~~ Individual plan of care and prior authorization of services

~~All residential behavior management services in a foster care setting (RBMS) are provided as a result of an individual assessment of the member's needs and documented in the individual plan of care. Services including individual plan of care development, individual therapy, family therapy, basic living skills (re)development, social skills (re)development, group rehabilitative treatment, substance abuse/chemical dependency education, prevention and therapy are provided per minimum requirements identified in this section. All services are based upon the member's individual plan of care and consistent with assessed needs. Individual therapy and family therapy may be provided in lieu of group rehabilitative therapy. Crisis behavior management and redirection services are provided as needed. The following represent the minimum service requirement for a member receiving Residential Behavior Management Services:~~

(a) All outpatient behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized.

(b) All outpatient behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.

(1) **Individual plan of care requirement.**

(A) A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within ~~30~~ 14 days of admission with documented input from the member, legal guardian (OKDHS/OJA) staff, the foster parent (when applicable) and the treatment provider(s). It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and have them fax back their signature; however, the provider must obtain the original signature for the clinical file within 30 days. No stamped or ~~Xeroxed~~ photocopied signatures are allowed. This plan must be revised and updated each 90 days with documented involvement of the legal guardian and resident.

(B) The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented full five-axis DSM-IV diagnosis, appropriate ~~long-term and short-term~~ goals, and corresponding reasonable and attainable ~~measurable~~ objectives ~~to obtain the stated goals~~ and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. ~~in each of the following areas:~~

~~(i) individual therapy;~~

~~(ii) substance abuse/chemical dependency education, prevention, and therapy;~~

~~(iii) group rehabilitative treatment;~~

~~(iv) family therapy;~~

~~(v) basic living skills (re)development;~~

~~(vi) social skills (re)development;~~

~~(vii) crisis/behavior management and redirection; and~~

~~(viii) discharge planning.~~

(C) Requests for outpatient behavioral services in a foster care setting will be approved for a maximum of three months.

~~(2) **Individual therapy.** The provider agency must provide individual therapy on a monthly basis to youth placed in the residential foster care homes. Individual therapy is a method of treating mental health and alcohol and other drug disorders using face to face, one to one interaction between a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d) and the member to promote behavioral, emotional or psychological change. Individual therapy is age appropriate and the techniques and modalities employed are relevant to the goals of the individual's plan of care. The required service for each member served is a minimum of four 30 minute sessions per month of individual therapy.~~

~~(3) **Group rehabilitative treatment.** The provider agency will provide group rehabilitative treatment as specified in the individual plan of care for the treatment of mental health and behavioral disorders for a minimum of two 30 minute sessions per month. Group rehabilitative services provided for children receiving RBMS in a foster care setting include educational and supportive services such as basic living skills, social skills (re)development, interdependent living, self care, lifestyle change and recovery principles. Services are provided in the least restrictive setting appropriate for the reduction of emotional and behavioral impairment and suitable to the restoration of the member's functioning. Services are consistent with the requirements of age and appropriate to the member's behavioral functioning and self sufficiency. Meeting with family members, legal guardian, and/or care givers is covered when the services are directed exclusively to the effective treatment of the individual member. Each service provided under this section must have a goal and purpose, which relates directly to the member's individual plan of care. Compensable rehabilitative treatment services are provided to members who have the ability to benefit from the service. The member must be able to actively participate and must possess the cognitive, developmental, and communication skills necessary to benefit~~

~~from the service. Travel time to and from activities is not covered. Staff to resident ratio shall not exceed eight children to one staff member. Staff appropriately trained, including training and certification in a recognized anger management intervention technique, such as MANDT or Controlling Aggressive Patient Environment (CAPE), must be present in the group. Thirty minutes of individual therapy and/or family therapy may be provided in lieu of one hour of group rehabilitative treatment.~~

~~(4) **Family therapy.** The provider agency must provide family therapy as indicated on the member's individual plan of care. Family therapy is an interaction between a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d) and the family member(s) designated on the individual plan of care. The interaction is intended to facilitate behavioral, emotional, or psychological change and promote understanding through successful communication skills. Family therapy must be provided for a minimum of four 30-minute sessions per month. The agency must:~~

~~(A) work with the caretaker to whom the member will be discharged, as identified by the OKDHS/OJA local worker;~~

~~(B) seek to support and enhance the child's relationships with nuclear and appropriate extended family members, if the OKDHS/OJA plan for the child indicates family reunification;~~

~~(C) arrange for and encourage regular contact and visitation between children and their parents and other family members as specified in the individual plan of care;~~

~~(D) seek to involve the child's parents/legal guardian in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program;~~

~~(E) provide consultation to the residential foster care parents;~~

~~(F) provide regular support and technical assistance to residential foster parents in their implementation of the individual plan of care and with regard to other responsibilities they undertake. Fundamental components of such technical assistance will be the design or revision of in-home treatment strategies including proactive goal setting and planning, and the provision of ongoing child specific skills training and problem solving in the home during home visits. Other types of support and supervision must include emotional support and relationship building, the sharing of information and general training to enhance professional development, assessment of the youth's progress, observation/assessment of family interactions and stress, and assessment of safety issues. Residential foster parents and their biological children must have access to counseling and therapeutic services arranged by the provider agency for personal issues/problems caused or exacerbated by their work as residential foster parents. Such issues may include, for example, marital stress, or abuse of their own child(ren) by a child placed in their care by the provider agency.~~

(2) **Description of Services.** Agency services include:

(A) **Individual, family and group therapy.** See OAC 317:30-5-241.2(a),(b), and (c).

(~~5~~B) **Substance abuse/chemical dependency ~~education, prevention and~~ therapy.** ~~The provider agency must provide substance~~ Substance abuse/chemical dependency therapy ~~for all members who are identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance abuse and/or chemical dependency. If a member is identified as requiring substance abuse/chemical dependency therapy, the provider agency must provide age appropriate substance abuse/chemical dependency therapy~~ can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance abuse and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. ~~For those members identified above, substance abuse/chemical dependency therapy must be provided a minimum of two one-hour sessions per month. In the case a member who has no identifiable emotional or behavioral problem directly related to substance abuse and/or chemical dependency, members must be provided age appropriate education and prevention activities. These may include self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums. For members who do not need substance and/or chemical dependency therapy, a minimum of two hours of education and/or prevention therapy per three month period is required.~~

(C) **Psychosocial rehabilitation (PSR).**

(~~6~~ i) **Basic living skills redevelopment.** ~~The provider agency must provide goal directed activities for each member to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopments are daily activities that are age appropriate and relevant to the goals of the individual plan of care. This may include, but is not limited to, food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, and job application and retention skills. Basic living skill redevelopment therapy must occur a minimum of 30 minutes each day.~~ Daily activities that are age appropriate and relevant to the goals of the individual plan of care. This may include, but is not limited to, food planning and preparation, maintenance of personal hygiene

and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, and job application and retention skills.

(~~7~~ii) **Social skills redevelopment.** ~~The provider agency must provide goal directed activities for each member to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self esteem enhancement, violence alternatives, communication skills or other related skill development curriculums approved by the provider agency. Social skill redevelopment therapy must occur a minimum of two 30 minute activities each day.~~ Goal directed activities for each member to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development.

(~~8~~iii) **Crisis/behavior management and redirection.** The provider agency must provide crisis/behavior redirection by agency staff as needed 24 hours per day, 7 days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption.

(~~9~~iv) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are ~~and~~ in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the Oklahoma Department of Human Services or the Office of Juvenile Affairs must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

317:30-5-743. Payment rates and recoupment [REVOKED]

~~(a) The payment rate for RBMS is a per diem (per day) amount for each child each day. The rate for this service is set by the Rates and Standards Committee of the Oklahoma Health Care Authority.~~

~~(b) In the case a recoupment is sought by the Oklahoma Health Care Authority because it determines that RBMS were not delivered or not delivered as required, a recoupment will be determined by:~~

~~(1) determining the value of the missing program requirements, and~~

~~(2) subtracting the value from the daily rate.~~

317:30-5-743.1. Inspection of Care

There will be an on site Inspection of Care of each Therapeutic Foster Care (TFC) agency that provides care to members which will be performed by the OHCA or its designated agent. The OHCA will designate the members of the Inspection of Care Team. This team will consist of two team members and will be comprised of Licensed Behavioral Health Professionals and/or Registered Nurses. The Inspection may include observation and contact with members. The Inspection of Care (IOC) review will consist of members present or listed as facility residents at the beginning of the Inspection of Care visit as well as members on which claims have been filed with OHCA for TFC services. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the on-site inspection, the Inspection of Care Team will report its findings to the ~~facility~~ agency. The ~~facility~~ agency will be provided with written notification if the findings of the Inspection of Care have resulted in any deficiencies. A copy of the final report will be sent to the ~~facilities'~~ agency's accrediting agency. Deficiencies found during the IOC may result in a ~~partial~~ recoupment ~~or a full recoupment~~ of the compensation received for that service. The individual plan of care is considered to be critical to the integrity of care and treatment and must be completed within the time lines designated at OAC 317:30-5-742.2. ~~For each day that the individual plan of care is not contained within the member's records, those days will warrant full per diem recoupment of the compensation received. If the review findings have resulted in a partial per diem recoupment of $10.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per diem recoupment status, the non compensable days of service will be reported in the notification. Penalties of non compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or anyone financially responsible for the member.~~ If the individual plan of care is missing or it is found that the child did not meet medical necessity criteria at any time, all

paid services will be recouped for each day the individual plan of care was missing from the date the plan of care was due for completion.

317:30-5-744. Billing

~~(a) Claims will be submitted monthly for each eligible recipient. A claim for that particular individual should include all reimbursable services provided during a given month.~~

(~~b~~a) Claims must not be submitted prior to OHCA's determination of the ~~client's~~ member's eligibility and must not be submitted later than 1 year after the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from ~~Medicaid~~ SoonerCare funds can be made should the individual be determined eligible at a later date.

(~~c~~b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the OHCA.

317:30-5-745. Documentation of records

All services must be reflected by documentation in the records including the date the service was provided, the beginning and ending time the service was provided, the location in which the service was provided, a description of the resident's response to the service and whether the service provided was an individual, group or family session, group rehabilitative treatment, social skills (re)development, basic living skills (re)development, crisis behavior management and redirection, or discharge planning, and the dated signature with credentials of the person providing the service.

[OAR Docket #10-739; filed 5-3-10]

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 60. ARCHIVES AND RECORDS COMMISSION
CHAPTER 15. ADMINISTRATION OF UNIFORM REAL PROPERTY ELECTRONIC RECORDING ACT

[OAR Docket #10-740]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 1. General Provisions [NEW]
60:15-1-1 [NEW]
60:15-1-2 [NEW]
60:15-1-3 [NEW]
60:15-1-4 [NEW]
Subchapter 3. Electronic Recording Standards [NEW]
60:15-3-1 [NEW]
60:15-3-2 [NEW]
60:15-3-3 [NEW]
60:15-3-4 [NEW]
60:15-3-5 [NEW]
60:15-3-6 [NEW]
60:15-3-7 [NEW]
60:15-3-8 [NEW]
60:15-3-9 [NEW]
60:15-3-10 [NEW]
60:15-3-11 [NEW]
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Uniform Real Property Electronic Recording Act, 16 O.S. Section 86.5
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SUPERSEDED EMERGENCY ACTIONS:
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INCORPORATIONS BY REFERENCE:
Incorporated Standards:
Property Records Industry Association (PRIA) Version 2 ERecording Standards, including the following documents: E-Recording Business Requirements dated March 12, 2008; Document Version 2.4.1 dated October 2007; Notary Version 2.4.1 dated October 2007; PRIA Request Version 2.4.2 dated August 2007; PRIA Response Version 2.4.2 dated August 2007; and Updated e Recording iGuide dated May 2007.
Incorporating Rules
60:15-3-1
Availability:
8:00 a.m. to 5:00 p.m., Monday through Friday at Archives Division, Oklahoma Department of Libraries, 200 N. E. 18 Street, Oklahoma City, OK 73105, 405-521-2502 or at www.pria.us .
ANALYSIS:
Chapter 15 rules establish standards and practices for the implementation of the requirements of the Oklahoma Uniform Real Property Electronic Recording Act (URPERA), created by the passage of House Bill 2587, passed by the Oklahoma Legislature during its 2008 session. 16 O.S.§ 86.1, et seq. These standards and practices will allow various parties involved in real property transactions to communicate and understand each other in a predefined manner.
CONTACT PERSON:
Jan Davis, Administrative Archivist, (405) 521-2502; Oklahoma Department of Libraries, 200 N.E. 18th Street, Oklahoma City, OK 73105, email address: jdavis@oltn.odl.state.ok.us

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 11, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

60:15-1-1. Purpose

The rules of this Chapter implement the Uniform Real Property Electronic Recording Act, as adopted in Oklahoma set out in Sections 86.1 through 86.7 of Title 16 of the Oklahoma Statutes, directing the Oklahoma Archives and Records Commission to establish standards for implementation of the Act.

60:15-1-2. Definitions

In addition to the definitions in the Uniform Electronic Transactions Act, as adopted in Oklahoma set out in Sections 15-101 through 15-121 of Title 12A of the Oklahoma statutes, and the Uniform Real Property Electronic Recording Act, the following words and terms shall be applied when implementing the Act.

"Act" means the Uniform Real Property Electronic Recording Act, as adopted in Oklahoma.

"Commission" means the Oklahoma Archives and Records Commission.

"E-Recording" means electronic recording.

"PRIA" means the Property Records Industry Association.

60:15-1-3. Glossary of Terms

The following words, terms, phrases, acronyms, and abbreviations are defined in other Oklahoma Statutes and are included here for use in connection with the Act or these rules, or are words, terms, phrases, acronyms, or abbreviations that may require further explanation to assist in the understanding of the Act and these rules.

(1) **ACH:** Automated Clearing House

(2) **Agreement:** means the bargain of the parties in fact, as found in their language or inferred from other circumstances and from rules, regulations, and procedures given the effect of agreements under laws otherwise applicable to a particular transaction.

(3) **ANSI:** American National Standards Institute

(4) **Asymmetric encryption:** A method of encryption that uses two keys, a public key and a private key. Together, the keys constitute a key pair. Although the keys are mathematically related, it is not possible to deduce one from the other. The public key is published in a public repository and can be freely distributed. The private key remains secret, known only to the key holder.

(5) **Authentication:** The act of tying an action or result to the person claiming to have performed the action. Authentication generally requires a password or encryption key to perform, and the process will fail if the password or key is incorrect.

(6) **Automated transaction:** means a transaction conducted or performed, in whole or in part, by electronic means or electronic records, in which the acts or records of one or both parties are not reviewed by an individual in the ordinary course in forming a contract, performing under an existing contract, or fulfilling an obligation required by the transaction.

(7) **Computer program:** means a set of statements or instructions to be used directly or indirectly in an information processing system in order to bring about a certain result.

(8) **Digitized signature or digital signature:** A representation of a handwritten signature, existing as a computerized image file. Digitized signatures are one of several types of electronic signatures, and have no relation to digital signatures.

(9) **DTD: Document Type Definition:** A document created using the Standard Generalized Markup Language (SGML) that defines a unique markup language such as XHTML or XML. A DTD includes a list of tags, attributes, and rules of usage.

(10) **Electronic commerce:** Also known as e-Commerce, refers to trade that occurs electronically, usually over the Internet. Electronic commerce often involves sharing information, buying or selling products, or extending both new and traditional services to customers via electronic means. Electronic commerce allows business to take advantage of e-mail, the Web, and other online innovations to improve the business process and offer consumers more ways to access products, faster information transfer and decreasing costs.

(11) **Electronic record:** A record created, generated, sent, communicated, received or stored by electronic means.

(12) **Electronic notary:** A notary public who provides electronic notarial acts pursuant to the provisions of section 86.3 of Title 16 of the Oklahoma Statutes.

(13) **Encrypt:** To apply an encryption key to a message in order to make it unreadable without a description key in an effort to prevent unintended use of the information.

(14) **E-SIGN:** Electronic Signatures in Global & National Commerce (15 U.S.C. Sections 7001 - 7006).

(15) **FTP:** File Transfer Protocol

(16) **Hash function:** A mathematical algorithm that takes an electronic document and creates a document fingerprint. The document fingerprint is much smaller than the original document, and does not allow the reconstitution of the original document from the fingerprint. A slightly different document, processed through the same hash function, would produce a very different document fingerprint. A hash function helps to secure data by providing a way to ensure that data is not tampered with.

(17) **HTML:** HyperText Markup Language

(18) **HTTP:** HyperText Transfer Protocol

(19) **HTTPS:** HyperTextTransfer Protocol Secure

(20) **Information:** means data, text, images, sounds, codes, computer programs, software, databases, or the like.

(21) **ISO:** International Standards Organization

(22) **Key pair:** A set of keys, including a private key and a public key, used in asymmetric encryption. Sometimes a key pair will be reserved for specific uses, such as creating digital signatures.

(23) **Metadata:** Commonly described as "data about data." Metadata is used to locate and manage information resources by classifying those resources and by capturing information not inherent in the resource.

(24) **Nonrepudiation:** Effectively implementing a process in such a way that the creator of a digital signature cannot deny having created it. Nonrepudiation involves supplying enough evidence about the identity of the signer and the integrity of a message so that the origin, submission, delivery, and integrity of the message cannot be denied. Protecting the private key of a user is also a critical factor in ensuring nonrepudiation. The entire Public Key Infrastructure (PKI) industry exists to create and ensure the trust necessary for nonrepudiation.

(25) **Notary public:** "Notary public" and "notary" mean any individual appointed and commissioned by the Oklahoma Secretary of State pursuant to the provisions of section 1 of Title 49 of the Oklahoma Statutes who performs notarial acts pursuant to the provisions of the Uniform Law on Notarial Acts, as adopted in Oklahoma set out in Sections 111 through 121 of Title 49 of the Oklahoma Statutes.

(26) **OAIS:** Open Archival Information Systems

(27) **PDF: Portable Document Format.** A file format created by Adobe Systems, Inc. that uses the PostScript printer description language to create documents. PDF files capture the appearance of the original document, can store both text and images, are difficult to modify, and can be rendered with free cross-platform viewer software.

(28) **Portal:** A Web site considered an entry point to other Web sites, often by being or providing access to a search engine, useful content, or by functioning as a gateway to other Web locations or both. Portals are usually provided free of charge, in the hope that users will use the site.

(29) **Private Key:** A large, randomly generated prime number used in asymmetric encryption. The private key is used to encrypt a document fingerprint which is the result of processing an electronic document through a hash function in order to create a digital signature. A private key is generated by its holder at the same time a related public key is created. While the public half of a key pair is made available to anyone, the private key is only known by its owner, who must keep it confidential to maintain its integrity.

(30) **Proprietary:** Indicates that software or other employed technology is owned or controlled exclusively by the vendor. These software solutions are not generally transferable to other systems without payment of license fees.

(31) **Public Key:** A large, randomly generated prime number used to decrypt an electronic document that has been encrypted with a private key. A public key is generated by its holder at the same time a related private key is created. Within the Public Key Infrastructure (PKI), public keys are used to verify digital signatures. Public keys are contained in digital certificates, published and otherwise distributed by the issuing certificate authority (CA).

(32) **PKI: Public Key Infrastructure.** The framework of different entities working together to create trust in electronic transactions. The PKI industry facilitates signed transactions by using asymmetric encryption to ensure security and verifiable authenticity. The PKI includes all parties, policies, agreements, and technologies applicable to a transaction. This infrastructure allows all concerned parties to trust electronic transactions created within the standards set by the PKI industry.

(33) **Schema:** A method for specifying the structure and content of specific types of electronic documents which use XML.

(34) **Security procedure:** means a procedure employed for the purpose of verifying that an electronic signature, record, or performance is that of a specific person or for detecting changes or errors in the information in an electronic record. The term "security procedure" includes a procedure that requires the use of algorithms or other codes, identifying words or numbers, encryption, or callback or other acknowledgment procedures.

(35) **SSL: Secure Socket Layer.** A security technology that uses both asymmetric and symmetric cryptography to protect data transmitted over the Internet.

(36) **Signature Authentication:** The process by which a digital signature is used to confirm the identity of a signer and the validity of the document.

(37) **Signed Digital Document:** An electronic document that includes an embedded digital signature. The digital signature contains an encrypted document fingerprint, which allows anyone receiving the document to verify its validity using the process of signature authentication.

(38) **Submitting Party:** The entity that originates an electronic document. This is usually a bank, title company, attorney, or anyone that either inputs data into a specific template or associates an image or both, and wishes to send the documentation for electronic recordation to the county clerk.

(39) **TIFF: Tagged Information File Format.** An image file format commonly used for photographs, scanned documents, or other graphics. TIFF images are graphics that are made up of individual dots or pixels. Files in the TIFF format are distinguished by a ".tif" filename extension. Group 4 TIFF (Tagged Image File Format) images are commonly used, because this format preserves the image in the most accurate and legible form.

(40) **TBP:** Trusted Business Partner.

(41) **Third party vendor:** Entity that may act as an intermediary in an electronic transaction. The vendor will usually add value to the transaction, such as verifying accuracy and completeness of index entries, authentication of the submitting party, or any other specific requirement of the county clerk.

(42) **Transaction:** means an action or set of actions occurring between two or more persons relating to the conduct of business, commercial, or governmental affairs.

(43) **UETA: Uniform Electronic Transactions Act.** The uniform act on which the Uniform Electronic Transactions Act as adopted in Oklahoma set out at Sections 15-101 through 15-121 of Title 12A of the Oklahoma Statutes was based authorizing electronic documents and digital signatures to stand as equals with their paper counterparts.

(44) **URPERA: Uniform Real Property Electronic Recording Act.** The uniform act on which the Uniform Real Property Electronic Recording Act as adopted in Oklahoma set out in Sections 86.1 through 86.7 of Title 16 of the Oklahoma Statutes, was based authorizing county clerks to accept electronic documents for recording in accordance with established standards.

(45) **VPN:** Virtual Private Network

(46) **Wet signature:** An original handwritten signature applied to a document.

(47) **XHTML:** Extensible HyperText Markup Language

(48) **XML Extensible Markup Language (XML):** A computer language used to create markup languages. XML allows developers to specify a document type definition (DTD) or schema in order to devise new markup languages for general or specific uses.

60:15-1-4. Authority, interpretation, and severability of rules

These rules are adopted pursuant to the provisions of the Uniform Real Property Electronic Recording Act, Sections 86.1 through 86.7 of Title 16 of the Oklahoma Statutes and the Administrative Procedures Act. Should a court of competent jurisdiction or the Attorney General of Oklahoma find any part of these rules to be inconsistent with the provisions of law as they presently exist or are hereafter amended, they shall be interpreted to comply with the statutes as they presently exist or are hereafter amended. The partial or total invalidity of any section of the Chapter shall not affect the valid sections.

SUBCHAPTER 3. ELECTRONIC RECORDING STANDARDS

60:15-3-1. Data and document standards

(a) The data and document standards and guidelines promulgated by PRIA Version 2 as follows and found at www.pria.us (date of search November 10, 2009) are hereby adopted by the Commission pursuant to the authority of Section 86.5 (a) and (b)(2) of Title 16 of the Oklahoma Statutes:

(1) E-Recording Business Requirements dated March 12, 2008,

(2) Document Version 2.4.1 dated October 2007,

(3) Notary Version 2.4.1 dated October 2007,

(4) PRIA Request Version 2.4.2 dated August 2007,

(5) PRIA Response Version 2.4.2 dated August 2007, and

(6) Updated e Recording iGuide dated May 2007,

(b) Upon any change in the data and document standards and guidelines or the models of submission the Commission will amend this section to reflect the amendment.

60:15-3-2. Web portals standards

(a) The World Wide Web is the most common delivery medium used for electronic documents, and use of web portals enables these transactions.

(1) Web portals can take on a variety of forms, from simple single entry sites used by an individual county clerk to support their own efforts, or by a collection of county clerks where the site provides both content and document routing.

(2) Web portals can be created by anyone, so long as the site supports all three PRIA models and complies with security requirements.

(3) The Commission shall not create or promote a mandatory Web portal.

(4) Each county clerk shall decide the portal used in their county.

(b) A document delivered over the Web shall provide a minimum amount of information in the electronic documents delivered which is sufficient to identify and authenticate the sender to the county clerk and an itemization of the contents of the package.

(c) Payment processing capabilities shall be determined by the county clerk with advice of a portal provider.

(1) Web portals may provide payment processing functionality.

(2) Payment processing, if supplied at the portal, shall comply with industry standards and any rules that may be promulgated by the Commission.

(3) Each county clerk is authorized to decide on approved methods of payment which could include but not be limited to debit or credit cards, ACH, and prepaid fee accounts.

60:15-3-3. Business rules

(a) Electronic Recording participants shall abide by the Business Rules of the county clerk.

(b) County clerks shall establish and publish Business Rules that govern the procedure for electronic recording.

(c) County clerks may modify their Business Rules as they deem necessary.

(d) The Business Rules may be in electronic or hard copy format and may appear on a portal or the website of the county clerk. Electronic acknowledgment of acceptance of the terms of the Business Rules is acceptable.

(e) The Business Rules shall include but not be limited to the following items:

(1) Defined technical specifications;

(2) Document and indexing specifications;

(3) Hours of operations and processing schedules;

(4) Payment options;

(5) Termination terms;

(6) Document Rejection rights;

(7) Process for publishing amendment to Business Rules; and

(8) Identification of the venue of any litigation arising between the parties.

60:15-3-4. Security

Participants of electronic recording shall develop security standards and policies based on industry-accepted security practices and protocols as approved by the Commission.

(1) **Transactional security.** All electronic documents shall be secured in such a way that both the transmitting and receiving parties are reasonably assured of the identity of each party and that no unauthorized party can view or alter the electronic document during transmission, processing, and delivery.

(2) **Organizational security.** Each county clerk, who elects to accept electronic documents for recording, shall implement reasonable measures to assure that each electronic document accepted for recording is protected from alteration and unauthorized access.

60:15-3-5. Electronic signatures

County clerks are only required to accept electronic signatures that they have the technology to support. County clerks shall have no responsibility to authenticate electronic signatures embedded within the body of the document.

60:15-3-6. Notary acknowledgment

County clerks shall have no responsibility for verifying or authenticating notary signatures and acknowledgments. Notarization and acknowledgment shall be subject to the provisions of section 86.3(c) of Title 16 of the Oklahoma Statutes, and Title 49 of the Oklahoma Statutes.

60:15-3-7. File formats for electronic recording

(a) Electronic recordings may be converted by the county clerk to and preserved as a Tagged Image File Format (TIFF) or Portable Document Format (PDF) files along with their associated metadata.

(b) Model 3 submissions shall be converted to TIFF or PDF until the viability of preserving these electronic recordings in their native format, such as Extensible Markup Language (XML) or Extensible HyperText Markup Language (XHTML) has been demonstrated.

60:15-3-8. Processing electronic recordings

County clerks shall process electronic recordings in accordance with the provisions of Section 298.1 of Title 19 of the Oklahoma Statutes, the Uniform Electronic Transaction Act as adopted in Oklahoma and the Act regarding accepting electronic documents for filing.

60:15-3-9. Records retention and preservation

(a) County clerks shall retain all records in their custody in accordance with sections 284 and 286 of Title 19, sections 15-112 and 15-117 of Title 12A, and sections 301 and 302 of Title 67 of the Oklahoma Statutes.

(b) The registrar of deeds records in the custody of the county clerk shall be permanently preserved. Producing security microfilm that is created within the guidelines of the American National Standards Institute (ANSI) and properly stored and handled is recommended. The Commission rules for microfilm can be found at: http://www.odl.state.ok.us/oar/docs/oar-rules.pdf, the Oklahoma Department of Libraries website.

60:15-3-10. Payment of recording fees

(a) Electronic payment of recording fees shall be collected by the county clerk as prescribed in accordance with Section 32.3 of Title 28 of the Oklahoma Statutes and accepted reasonable industry standards.

(b) Payments are a prerequisite to all methods of recording as required by section 292 of Title 19 of the Oklahoma Statutes.

(c) Each county clerk may collect electronic recording fees in a manner compatible with their internal software and financial practices.

60:15-3-11. E-Recording Models

(a) Electronic recordings, whether as pilot projects or live production initiatives, have occurred in many states. From these efforts, three distinct models have emerged. The models are referred to as Models 1, 2, and 3. Each has distinctive characteristics. Each also brings certain benefits to the submitters.

(b) Over time the improvements in delivery methods and document formats have improved the processes as well. From scanned paper documents, to electronically signed images of the documents wrapped with XML data and securely signed, to completely electronic, XML-integrated documents using electronic and digital signatures, these models bring continuing benefits to participating county clerks and document submitters. Ongoing progress with increasing value from added benefits are expected as mortgage, legal, and recording industry standards are implemented.

(1) **Model 1 Description.** This model is an extension of the paper-based closing or payoff processes. Documents are prepared and printed. The parties sign and notarize the paper documents with ink signatures. When complete, the signed and notarized paper documents are scanned and electronically sent to the county clerk. Transmission is done by the submitting parties logging on to the computer system of the county clerk over a secure network after first identifying, or authenticating, themselves to the computer of the county clerk. The county clerk makes the same determination of recordability as with paper documents, visually inspecting them for such things as signatures and acknowledgments as well as determining the recording fees. Once the county clerk accepts the documents for recording, the scanned image is permanently affixed with the recording information, including recording date and time as well as the unique recording reference number, such as book and page number or instrument number. Indexing is performed by the indexing staff of the office of the county clerk, as with paper documents. A copy of the recorded images is returned to the submitter, together with the recording endorsement data and receipt.

(2) **Model 2 Description.** Model 2 recordings may be paper or electronic based. A document image whether from a scanned paper document signed and notarized by 'wet ink' signatures or from an electronic document electronically signed and notarized, is wrapped in an XML wrapper containing the data necessary for processing, indexing, and returning the document. In the case of a scanned paper document, Model 2 further extends Model 1 by adding data that improves the process, specifically the indexing process in the office of the county clerk. In the case of an electronic document, the process begins to improve for the settlement agent, lender, or loan servicer submitting the document. The model may support one or more of a number of graphics formats. The recordable electronic documents are generally delivered to the office of the county clerk by whatever means agreed to by the parties as specified in the Business Rules. Once imported into the system of the county clerk, the legacy system handles the recording functions. In this case the system imports the data from an XML wrapper, including index data. The recording process is partially automated, but the image may be visually inspected to determine that it meets recording requirements as well as possibly to validate against the data in the XML wrapper. The indexing

data in the embedded image is not linked to the index data in the XML, so the county clerk has no automated means to verify that it is the same. If a document meets the requirements of the county clerk, it is recorded.

(3) **Model 3 Description.** Under Model 3, documents are generated on a Trusted Business Partner's document preparation system according to the PRIA standards. The document preparation person logs on to the system and enters the information necessary to complete the generation of the document. Once the document has been generated, it is signed by an individual with the authority to sign. Secure access is required for all parties that must sign the document because signing is done by electronic signature. Once the documents are electronically prepared, they are released for recording. The document preparation system compares each document against recording rules to ensure its recordability, and then calculates recording fees. Documents are submitted to the office of the county clerk pursuant to the terms of the Business Rules of the county clerk. Documents received at the office of the county clerk are re-checked against the rules to determine whether or not they may be recorded. If not, they are returned to the submitter. Otherwise they are accepted for recording and the data for recording is extracted from the documents and passed to the legacy recording system. The endorsement data is received from the legacy system and entered onto the respective documents in XML format. If required, the XHTML is transformed to images for the archives of the county clerk and the documents with the recording endorsements are returned to the submitter.

[OAR Docket #10-740; filed 5-3-10]

TITLE 140. BOARD OF CHIROPRACTIC EXAMINERS
CHAPTER 10. LICENSURE OF CHIROPRACTIC PHYSICIANS

[OAR Docket #10-768]

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Subchapter 1. General Provisions
140:10-1-2 [AMENDED]
Subchapter 3. Application, Examination and Licensing
140:10-3-1 [AMENDED]
140:10-3-3 [AMENDED]
140:10-3-5 [AMENDED]
Subchapter 5. Procedures for Renewal Licenses
140:10-5-1 [AMENDED]
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The Oklahoma Board of Chiropractic Examiners needed to amend language to keep language in line throughout OAC 140 so that each section provides the same meaning.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FOR THE IN 75 O.S., SECTION 308.1 (A), WITH AN EFFECTIVE DATE OF JUNE 11, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

140:10-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise. In addition, the use of the masculine gender shall be deemed inclusive in this chapter to include the feminine gender.

"Accredited chiropractic college" means a chiropractic educational institution which is accredited by the Commission on Accreditation of the Council on Chiropractic Education, a national, independent accreditation body recognized and approved by the U.S. Department of Education.

"Act" means the Oklahoma Chiropractic Practice Act, 59 O.S. 1991, §§161.1 et seq.

"Advisory Committee" means the committee appointed by the Board to advise and assist the Board in the investigation of the qualifications for licensure, complaints as to the conduct of chiropractic physicians, and for such other matters as the Board delegates to them.

"Board" means the Board of Chiropractic Examiners.

"Chiropractic" means the science and art that teaches health in anatomic relation and disease or abnormality in anatomic disrelation, and includes hygienic, sanitary and therapeutic measures incident thereto.

"Chiropractic physician" or "licensee" means a person who holds an original license to practice chiropractic in this state.

"Continuing education requirements" means attendance by a licensee at a minimum of sixteen (16) hours of

Chiropractic education seminars as required for a renewal license.

(A) Twelve (12) hours of the sixteen required by law must be clinical in nature, and the other remaining four (4) may consist of practice management, philosophy, and or other non-clinical topics.

(B) Eight (8) hours of continuing education may be acquired out of state with first having obtained a pre-approval from the Board of Chiropractic Examiners. Eight (8) hours of continuing education can be obtained by attending a national chiropractic association meeting and/or the Federation of Chiropractic Licensing Boards Annual or Federation of Chiropractic Licensing Boards' District meetings attended by any licensee.

(C) Eight (8) hours of mandatory in state continuing education shall be acquired by attending continuing education offered by a registered, domesticOklahoma association whose seminar has been approved by the Board of Chiropractic Examiners.

"Examination" means the process used by the Board, prior to the issuance of any original license, to test the qualifications and knowledge of an applicant on any or all of the following: current statutes, rules, or any of those subjects listed in Section 161.8 of the Act.

"Individual proceeding" means the formal process employed by the Board to provide a hearing for a licensee of the Board accused of a violation of the Act and in which the Board may take action against such person's original license to practice chiropractic in this state.

"License renewal program" means a continuing education program which:

(A) is sponsored or administered by an association for the purpose of providing licensees an opportunity to satisfy continuing education requirements; and

(B) has been approved by the Board.

"Licensure" means the Board's process with respect to the grant, denial, renewal, revocation, or suspension of an original or renewal license.

"Original license" means a license which grants initial authorization to practice chiropractic in this state issued by the Board to an applicant found by the Board to meet the requirements for licensure of the Act:

(A) by examination pursuant to § 161.7 and 161.8 of the Act and 140:10-3-1 through140:10-3-4; or

(B) by relocation of practice pursuant to § 161.9 of the Act and140:10-3-5.

"Relocation of practice" means the ability of an applicant to obtain Oklahoma who meets the following conditions:

(A) The applicant is of good moral character;

(B) The requirements for licensure in the state, country, territory or province in which the applicant is licensed are deemed by the Board to be equivalent to the requirements for obtaining an original license by examination in this state at the date of such license;

(C) The applicant has no disciplinary matters pending against him or her in any state, country, territory or province;

(D) The license held prior to relocation of practice was obtained by examination in the state, country, territory or province wherein it was issued, or was obtained by examination of the National Board of Chiropractic Examiners;

(E) The applicant passes any examination offered by the Board according to140:10-3-1; and

(F) The applicant meets all other requirements of the Oklahoma Chiropractic Practice Act.

"Renewal license" means a license issued by the Board on or before the first day of July ~~January~~ of each year to a licensee which authorizes the licensee to practice chiropractic in this state for the succeeding calendar year.

"Revocation" means the recalling, annulling or rendering inoperative of an original license or renewal license, or both, by the Board, after notice and an opportunity for a hearing in an individual proceeding.

SUBCHAPTER 3. APPLICATION, EXAMINATION AND LICENSING

140:10-3-1. Application for an original license by examination

(a) An application to the Board for an original license to practice chiropractic shall be made on forms created and approved by the Board and shall be signed and verified under oath by the applicant. The application shall include:

(1) A passport photo

(2) the affidavits of two (2) chiropractic physicians who are not related to or under financial obligation to the applicant and which state that the applicant is of good moral character;

(3) a copy of the applicant's high school diploma or transcripts, certified as being a true and correct copy

(4) a copy of the applicant's pre-chiropractic college or university transcript or transcripts, certified:

(A) by an official of the issuing college or university as being true and correct; and

(B) by an official of the University of Oklahoma as containing at least ninety (90) hours of college credit accepted by the University of Oklahoma;

(5) a copy of the applicant's diploma from an accredited chiropractic college, certified by an official of the issuing college as being true and correct, except asprovided in (b) of this Section;

(6) A money order, certified check or cashier's check payable to the Board in the amount of One Hundred Seventy-Five ~~Fifty~~ Dollars ($175.00) ~~($150.00)~~ as payment of the application fee. Such fee is not refundable under any circumstances.

(b) A senior student at an accredited chiropractic college may, prior to graduation, make application for an original license by examination. In such event, the application shall be accompanied by a statement on a form approved by the Board containing certification by an official of such college that the applicant is a senior at the college and is expected to graduate

with in one (1) year from the date of the certificate. An original license shall not, however, be issued to such an applicant until the applicant has submitted to the Board a copy of the applicant's diploma from said accredited chiropractic college, certified as true and correct.

(c) Applicants shall submit documentary evidence of completion of Parts I, II, III, IV and physiotherapy as administered by the National Board of Chiropractic Examiners with a passing score.

(d) An application and all accompanying documents must be completed and received by the Board no later than thirty (30) days prior to the date of the next scheduled examination in order to be eligible to take the examination.

(e) A fee of One Hundred Seventy-Five ~~Fifty~~ Dollars ($175.00) ~~($150.00)~~ as payment for the examination if approved by the Board of Chiropractic examiners. Such fee is not refundable under any circumstances.

140:10-3-3. Examination Fee

Each application for an original license shall be accompanied by a non-refundable examination fee of One Hundred Seventy-Five ~~Fifty~~ Dollars ($175.00) ~~($150.00)~~, made payable to the Board, which payment shall be by money order, certified check or cashier's check, and which shall be submitted with the application.

140:10-3-5. Application for an original license by relocation of practice.

(a) An application to the Board for an original license by relocation of practice to practice chiropractic in this state shall be made on a form created and approved by the Board and the applicant may also be required to appear before the board for a personal interview, and shall be assessed a jurisprudence examination

(b) The Board may, in its discretion, refuse to grant an original license by relocation of practice to any applicant and may require the applicant to take the oral examination required by the Act.

(c) The application shall be signed and verified under oath by the applicant. The application shall include:

(1) A passport photo attached to the appropriate page of the application.

(2) the affidavits of two (2) chiropractic physicians who are not related to or under financial obligation to the applicant and which state that the applicant is of good moral character;

(3) a copy of the applicant's high school final transcripts or equivalent certified as being a true and correct copy;

(4) a copy of the applicant's pre-chiropractic college or university transcript or transcripts, certified:

(A) by an official of the issuing college or university as being true and correct; and

(B) by an official of the University of Oklahoma as containing at least ninety (90) hours of college credit accepted by the University of Oklahoma;

(5) a copy of the applicant's diploma from an accredited chiropractic college, certified by an official of the issuing college as being true and correct;

(6) Submit documentary evidence to the board that the applicant has been in active practice for five (5) years immediately preceding the date of application.

(7) a money order, certified check or cashier's check payable to the Board, in the amount of Three Hundred Fifty Dollars ($350.00) ~~($300.00),~~ as payment of the application fee. Such fee is not refundable under any circumstances.

(d) Except as is otherwise approved in writing by the Board, an application and all accompanying documents must be completed as set forth in the Act and application.

(e) All documents accompanying an application for an original license by relocation of practice that are written in any language other than English shall be translated, at the expense of the applicant, into the English language and certified under seal of the proper consulate. The translation shall be submitted with the application.

(f) All applicant's must submit a certified copy of his/her birth certificate and/or naturalization papers if they were born anywhere other than the United States.

(g) The review of each application for an original license by relocation of practice shall be conducted by the Board, and notice of the approval or disapproval thereof shall be given by the Executive Director in the same manner as for an application for an original license by examination.

(h) A fraudulent or false statement as to any material fact, which is contained in any application for an original license by relocation of practice, or the failure to provide any requested information, shall constitute sufficient cause for the disapproval of the application.

SUBCHAPTER 5. PROCEDURES FOR RENEWAL LICENSES

140:10-5-1. Renewal license; requirements

(a) Except as provided in 140:10-5-4, related to senior inactive licenses, and 140:10-5-5, related to nonresident licenses, each licensee holding an original license to practice chiropractic in this state shall pay to the Board, on or before the first day of July ~~January~~ of each year hereinafter, an annual renewal fee of Two Hundred Twenty-Five Dollars ($225.00), which shall be accompanied by;

(1) Evidence that the licensee has satisfied Board approved chiropractic continuing education requirements; or

(2) A statement on a form created and approved by the Board, containing:

(A) An affidavit from the licensee which states:

(i) the licensee was unavoidably prevented from satisfying the continuing education requirements;

(ii) the reason or reasons therefore; and

(iii) that the licensee is not attempting to circumvent or abrogate the intent of such continuing education requirements; and

(B) the affidavits of two (2) licensed chiropractic physicians who personally know the licensee, vouch for the licensee's good standing in the chiropractic profession, and recommend that the licensee be issued a renewal license.

(b) The Board shall, upon receipt of the renewal license fee, and upon determination of compliance with the requirements of subsection A of Section 161.11 of the Act, issue a Chiropractic renewal license, which shall entitle the holder to practice chiropractic in this state during the succeeding calendar year.

(c) Attendance by a licensee at a license renewal program shall be certified by an officer of the sponsoring or administering association, which officer shall have been previously approved by the Board for the purpose of providing such certification. The list of attendees from the continuing education seminar, shall be submitted no later than forty-five (45) days after the approved continuing education seminar. The list shall be submitted by the certified officer of the association, and sent to the Board after all signatures and/or time cards have been verified by the individual certified to report to the Board of Chiropractic Examiners on all seminar attendees. If there are any missing signatures and/or any other missing documentation the licensee will not be able to renew his/her license for the renewal year.

(d) Individuals who take the allowable eight (8) hours of an approved out of state educational seminar shall be responsible for obtaining proof of attendance. The doctor shall submit proof of attendance with renewal application.

(e) The Board of Chiropractic Examiners hereby recognizes the requirements adopted from time to time by the Federation of Chiropractic Licensing Boards Providers of Approved Continuing Education (FCLB PACE) as the requirements of the Board. The Board recognizes FCLB PACE Recognized Providers as satisfying the requirements of the Board for purposes of the licensure renewal process. The Board, however, reserves the approval authority for all programs based on furtherance of professional development and related areas, and in the interest of the public protection.

SUBCHAPTER 8. ADMINISTRATIVE FEES

140:10-8-1. Fees

Fee Schedule.

(1) Examination. The following fees shall be assessed for licensure and examinationof Chiropractors:

(A) Original license: $175.00 ~~$150.00~~

(B) Relocation of Practice: $175.00 ~~$150.00~~

(C) Examination Fee: $175.00 ~~$150.00~~

(2) Licensure. The following fees shall be assessed for licensure of Chiropractors:

(A) Renewal fee active license $225.00

(B) Renewal fee inactive license $175.00

(C) Retired license fee $50.00

(D) Reinstatement fee not exceed $400.00

(E) Penalty fee for late renewal $150.00

(3) Duplication or modification of license. A fee of $75.00 shall be assessed for duplication or modification of original license.

(4) Miscellaneous fees: the following fees shall be assessed by the Board

(A) Letter of good standing and/or verifications for other licensing Boards with seal: $35.00

(B) Verification of licensure: $10.00 per license

(C) Duplication of proof of license renewal: $10.00

(D) Duplication of Public Records: per page: $0.25

(E) Returned check processing fee: $20.00

(F) Duplication of certificates issued by the Board: $20.00

(G) Directory $35.00 hard copy and/or diskette

(H) Search fee for records requested for commercial purposes: $30.00

(I) Continuing education application fee: ~~$200.00~~ $300.00

(J) Post Doctoral Diplomate Chiropractic Specialties registration/re-registration fee: $50.00

(K) Copy of tape of a board meeting and or an administrative hearing $20.00

(L) Labels of addresses of all licensed chiropractors $50.00

(M) Travel-to-Treat registration $25.00

(N) Non-attendance application request $50.00

[OAR Docket #10-768; filed 5-5-10]

TITLE 140. BOARD OF CHIROPRACTIC EXAMINERS
CHAPTER 15. SPECIAL CERTIFICATIONS AND MISCELLANEOUS PROVISIONS

[OAR Docket #10-769]

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Subchapter 12. Naturopathy
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N/A
ANALYSIS:
The Oklahoma Board of Chiropractic Examiners needed to amend language to keep language in line with language presently in the statutes and throughout OAC 140 so that each section provides the same meaning.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FOR THE IN 75 O.S., SECTION 308.1 (A), WITH AN EFFECTIVE DATE OF JUNE 11, 2010:

SUBCHAPTER 11. HOMEOPATHY

140:15-11-1. Registration from the Board

Only a chiropractic physician who has satisfactorily completed education in homeopathy and has received a certificate in homeopathic medicine from an accredited chiropractic college or institution recognized by the board and upon registration from the Board, may hold himself or herself out to the public as a specialist certified in homeopathic medicine. This rule does not apply to persons licensed to practice chiropractic in Oklahoma who graduated from a chiropractic institution on or before ~~after~~ January 1, 2000.

SUBCHAPTER 12. NATUROPATHY

140:15-12-1. Registration from the Board

Only a chiropractic physician who has satisfactorily completed education in naturopathy and has received a certificate in naturopathic medicine from an accredited chiropractic college or institution recognized by the board and upon registration from the Board, may hold himself or herself out to the public as a specialist certified in naturopathic medicine. This rule does not apply to persons licensed to practice chiropractic in Oklahoma who graduated from a chiropractic institution on or before ~~after~~ January 1, 2000.

[OAR Docket #10-769; filed 5-5-10]

TITLE 195. BOARD OF DENTISTRY
CHAPTER 2. INTERNAL OPERATIONS AND PROCEDURES

[OAR Docket #10-688]

RULEMAKING ACTION:
Permanent Final Adoption.
RULES:
195:2-1-7. Fees [AMENDED]
AUTHORITY:
Title 59 O.S. Supp. 1996, Section 328.15(A), Board of Dentistry
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NA
INCORPORATIONS BY REFERENCE:
NA
ANALYSIS:
Board is increasing fees to cover shortfall experienced in FY 2009. Not all fees have been increased. Fees are still below the maximum enacted by legislature in 59 O.S. Section 328.51a.
CONTACT PERSON:
Linda C. Campbell, Executive Director, (405) 524-9037

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, 2010:

195:2-1-7. Fees

Fees charged by the Board are hereby set as follows:

(1) LICENSE, CERTIFICATE AND PERMIT APPLICATION FEES:

(A) License or Certificate by Examination

(i) Dentist - $200.00

(ii) Dental Hygienist - $100.00

(B) License or Certificate by Credentialing

(i) Dentist - $500.00

(ii) Dental Hygienist - ~~$100.00~~ $150.00

(C) Dental Specialty License by Examination - $300.00

(D) Dental Specialty License by Credentialing - $500.00

(E) Faculty Permit

(i) Dentist - $100.00
(ii) Dental Hygienist - $50.00
(F) Dental Intern Permit - $100.00
(G) Temporary Certificate to Practice Dental Hygiene - $50.00
(H) Dental Assistant permit for Expanded Duties - $10.00
(I) Permit to Operate a Dental Laboratory - $20.00
(J) General Anesthesia Permit Dentist - $100.00
(K) Conscious Sedation Permit Dentist - $100.00

(2) RE-EXAMINATION FEES:
(A) License or Certificate by Examination
(i) Dentist - $200.00
(ii) Dental Hygienist - $100.00
(B) Dental Specialty License by Examination - $300.00
(C) Theoretical or Written Only Re-Examination
(i) Dentist - $10.00
(ii) Dental Hygienist - $10.00

(3) ANNUAL RENEWAL FEES:
(A) Dentist - ~~$125.00~~ $150.00
(B) Dental Hygienist - ~~$65.00~~ $75.00
(C) Dental Specialty License - ~~$100.00~~ $150.00
(D) Faculty Permit
(i) Dentist - $50.00
(ii) Dental Hygienist - $50.00
(E) Dental Intern Permit - $50.00
(F) Dental Assistant permit for Expanded Duties - ~~$20.00~~ $25.00
(G) Permit to Operate a Dental Laboratory - $20.00
(H) General Anesthesia Permit Dentist - $100.00
(I) Conscious Sedation Permit Dentist - $100.00

(4) PENALTY FEES FOR LATE RENEWAL OF LICENSE, CERTIFICATE OR PERMIT:
(A) Dentist - $100.00
(B) Dental Hygienist - $50.00
(C) Dental Specialty License - $100.00
(D) Dental Assistant Permit for Expanded Duties - $20.00
(E) Permit to Operate a Dental Laboratory - $20.00
(F) General Anesthesia Permit Dentist - $100.00
(G) Conscious Sedation Permit Dentist - $100.00

(5) OTHER FEES:
(A) Duplicate License - $10.00
(B) Duplicate Certificate, Permit or Registration - ~~$5.00~~ $10.00
(C) Certificate of Good Standing - ~~$5.00~~ $10.00
(D) Professional Entity Certification Letter - $5.00
(E) Professional Entity Registration or Update - ~~$5.00~~ $20.00
(F) Work Authorization Books - ~~$4.00~~ $7.00
(G) Preparation of list of Dentists, Dental Hygienists, Dental Assistants who hold a Permit for Expanded Duties, and holders of a permit to Operate a Dental Laboratory - $75.00 (All lists must be requested in writing noting the specific use of the list.)
(H) Copies of Public Records - per page - $0.25

[OAR Docket #10-688; filed 4-26-10]

TITLE 195. BOARD OF DENTISTRY
CHAPTER 4. CATASTROPHIC HEALTH EMERGENCY PLAN

[OAR Docket #10-689]

RULEMAKING ACTION:
Permanent Final Adoption.
RULES:
195:4-1-1 [NEW]
195:4-1-2 [NEW]
AUTHORITY:
Title 59 O.S. Supp. 1996, Section 328.15(A), Board of Dentistry
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SUPERSEDED EMERGENCY ACTIONS:
NA
INCORPORATIONS BY REFERENCE:
NA
ANALYSIS:
Board is adopting new rules that will facilitate the recommendations for including Dentistry in the Oklahoma Catastrophic Health Emergency Plan.
CONTACT PERSON:
Linda C. Campbell, Executive Director, (405) 524-9037

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, 2010:

195:4-1-1. Purpose

The Board of Dentistry shall recognize a declared emergency and implement the existing Catastrophic Health Emergency Plan. All alternative standards of care shall be authorized during an official declared emergency as directed by the Board of Dentistry. The Executive Director shall be responsible for coordination of the dental profession's response, maintenance of necessary dental databases and activation of an emergency "phone tree"

195:4-1-2. Recognition of dental providers

Dentists, dental hygienists and dental assistants should be considered as "acting within the scope of his or her profession when providing all needed care during a declared local, state or national emergency", and should be allowed to perform services requested of them when working under the supervision of a dentist or physician.

[OAR Docket #10-689; filed 4-26-10]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 15. CURRICULUM AND INSTRUCTION

[OAR Docket #10-773]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 3. Priority Academic Student Skills
Part 25. Technology ~~Education~~Engineering
210:15-3-196. Overview of technology ~~education~~engineering for grades 6-10 [AMENDED]
210:15-3-197. Technology ~~education~~engineering for grades 6-10 [AMENDED]
AUTHORITY:
70 O. S. § 3-104, State Board of Education
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Superseded rules:
Subchapter 3. Priority Academic Student Skills
Part 25. Technology ~~Education~~Engineering
210:15-3-196. Overview of ~~education~~engineering for grades 6-10 [AMENDED]
210:15-3-197. Technology ~~education~~engineering for grades 6-10 [AMENDED]
Gubernatorial approval:
July 2, 2009
Register Publication:
26 Ok Reg 2956
Docket Number:
09-1209
INCORPORATION BY REFERENCE:
N/A
ANALYSIS:
The proposed rule amendments provide additional clarity and detail to the standards for Technology Education set forth in the Priority Academic Student Skills. The changes reflect terminology and concepts in common usage within the technology education profession and specify that certain objectives regarding the teaching of career clusters shall be adopted.
CONTACT PERSON:
Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2010:

SUBCHAPTER 3. PRIORITY ACADEMIC STUDENT SKILLS

PART 25. TECHNOLOGY ~~EDUCATION~~ENGINEERING

210:15-3-196. Overview of technology ~~education~~engineering for grades 6 - 10

(a) Technology ~~Education~~Engineering in Oklahoma is an instructional program offered for elective credit that provides young men and women (Grades 6-10) with daily, hands-on exploratory experiences and insights into technology and career opportunities so that they can make meaningful occupational and educational choices.

(b) Technology ~~Education~~Engineering capitalizes on the individual's potential for reasoning and problem solving, for imagining and creating, and for constructing and expressing through the use of tools and materials related to technology. It develops content and experiences to contribute to the growth and development of students commensurate with their potential. Technology ~~Education~~Engineering is a basic and fundamental study for all persons in regard to career explorations and educational opportunities.

(c) Opportunities to develop and apply leadership, social, civic and technologically related skills are provided through the Technology Student Association (TSA).

(d) All Technology ~~Education~~Engineering courses are taught with each of the ~~four~~career clusters ~~Technology systems (communications, construction, manufacturing and transportation, energy and power) being designed to provide~~providing a means through which other courses such as math, science, language arts and social studies can be applied in a practical manner within a technology-based situation. Teaching across the curriculum is vital to the success of a Technology ~~Education~~Engineering program.

210:15-3-197. Technology ~~education~~engineering for grades 6 - 10

(a) **Standard.** The student will define the characteristics and scope of technology and engineering in our world today.

(1) Examine the evolution, application and significance of modern technology engineering and its impact on our lives in the twenty-first century.

(2) Identify the effects and reasons for commercialization of technology.

(b) **Standard.** The student will identify the core concepts of technology systems, resources and processes including optimization and trade-off concepts.

(c) **Standard.** The student will identify and describe the importance of technology and the relationships between and among technology and other fields.

(1) Recognize and describe technology transfer from one product to another.

(2) Recognize and describe inventions and innovations shared across new technologies.

(d) **Standard.** The student will identify and differentiate the cultural, social, economic and political effects of technology and engineering.

(1) Determine the impact and consequences of technology.

(2) Identify and describe the rapid or gradual changes in technology and the related effects.

(e) **Standard.** The student will recognize the effects of technology and engineering on the environment.

(1) Describe technologies used to repair damage in the environment.

(2) Examine ways to reduce resource use through technology engineering concepts.

(3) Identify practices available for monitoring the environment to provide feedback for decisions.

(f) **Standard.** The student will determine the connection between technological demands, values and interests of society and the impact of these on the environment.

(g) **Standard.** The student will identify the history and evolution of technology engineering techniques, measurements and resources.

(h) **Standard.** The student will apply the technology engineering design process to create useful products and systems.

(1) Identify criteria required to determine an effective technology engineering design process.

(2) Apply reasoning, problem solving, imagining, creating and constructing design and technology tools.

(i) **Standard.** The student will describe technological advances that enhance science and mathematics and describe how science and mathematics advance technology and engineering.

(j) **Standard.** The student will apply problem-solving and critical thinking techniques for troubleshooting, research and development, invention and innovation and experimentation and implement these strategies as a multidisciplinary approach.

(k) **Standard.** The student will apply creativity in developing technology products and systems.

(1) A model to explain a solution to a problem.

(2) Test and evaluate a design for improvement.

(3) Identify quality controls necessary in a technology product or system process.

(l) **Standard.** The student will apply safe and proper use of tools, machines, materials, processes and technical concepts.

(m) **Standard.** The student will assess the impact of technology engineering on products and systems.

(1) Design and use instruments to collect data for a product.

(2) Use collected data to find trends and assist in technological development.

(3) Interpret and evaluate accuracy of information to determine its usefulness.

(4) Synthesize data to draw conclusions regarding the effects of technology and engineering.

(5) Design forecasting techniques to evaluate results of altering natural resources.

(n) **Standard.** ~~The student will identify and describe advances and innovation in the energy power, biotechnology, communications, transportation, manufacturing, construction, and agriculture techniques used to improve each field.~~The student will identify and describe advances and innovation in the career clusters with an emphasis in Arts/AV, Architecture and Construction, Manufacturing, Transportation Distribution and Logistics, and Science Technology Engineering Math (STEM).

(o) **Standard.** ~~The student will identify and describe energy power, biotechnology, communications, transportation, manufacturing, construction, and agriculture technology principles necessary to create products and processes.~~The student will identify and describe the career clusters with an emphasis in Arts/AV, Architecture and Construction, Manufacturing, Transportation Distribution and Logistics, and Science Technology Engineering Math (STEM) principles necessary to create products and processes.

(p) **Standard.** ~~The student will identify and define how energy power, biotechnology, communications, transportation, manufacturing, construction, and agriculture technologies apply to various occupational clusters.~~The student will identify and define how the career clusters with an emphasis in Arts/AV, Architecture and Construction, Manufacturing, Transportation Distribution and Logistics, and Science Technology Engineering Math (STEM) apply to various occupational clusters.

(q) **Standard.** ~~The student will identify how technology systems are effected by energy power, biotechnology, communications, transportation, manufacturing, construction, and agriculture.~~The student will identify how technology and engineering systems are affected by career clusters with an emphasis in Arts/AV, Architecture and Construction, Manufacturing, Transportation Distribution and Logistics, and Science Technology Engineering Math (STEM).

(1) ~~Apply energy power, biotechnology, communication, transportation, manufacturing, construction, and agriculture systems and subsystems to a model.~~Apply the career clusters with an emphasis in Arts/AV, Architecture and Construction, Manufacturing, Transporation Distribution and Logistics, and Science Technology Engineering Math (STEM) systems and subsystems to a model.

(2) ~~Recognize and define the purpose and uses for information skills as it relates to energy power, biotechnology, communication, transportation, manufacturing, construction, and agriculture technologies.~~Recognize and define the purpose and uses for information skills as it relates to the career clusters with an emphasis in Arts/AV, Architecture and Construction, Manufacturing, Transportation

Distribsution and Logistics, and Science Technology Engineering Math (STEM).

(r) **Standard.** The student will develop leadership, positive self-concepts, and individual potential in a technological society.

(s) **Standard.** The student will explore the organization and management systems of business and industry.

(t) **Standard.** The student will explore career opportunities to determine occupational and educational choices.

(1) Examine opportunities related to specific occupations (e.g. career search software, field trips, guest speakers and hands-on activities dealing with lasers, medical, technology, fiber-optics, robotics, biotechnology, computer-aided drafting, electronics, engineering, computer literacy, microwave systems, and other technology systems.)

(2) Examine educational opportunities related to future careers related to career clusters (e.g. additional career technology classes at the secondary level in the comprehensive high school and area career technology centers, junior or four-year universities, postsecondary technical institutes, five- and six-year universities, military training, private sector training, and others.)

[OAR Docket #10-773; filed 5-6-10]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 15. CURRICULUM AND INSTRUCTION

[OAR Docket #10-775]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Priority Academic Student Skills
Part 3. Pre-Kindergarten and Kindergarten [AMENDED]
210:15-3-5.3. Language arts for pre-kindergarten and kindergarten [AMENDED]
Part 5. Language Arts
210:15-3-12. Language arts for grade 1[AMENDED]
210:15-3-13. Language arts for grade 2 [AMENDED]
210:15-3-14. Language arts for grade 3 [AMENDED]
210:15-3-15. Language arts for grade 4 [AMENDED]
210:15-3-16. Language arts for grade 5 [AMENDED]
210:15-3-17. Language arts for grade 6 [AMENDED]
210:15-3-18. Language arts for grade 7 [AMENDED]
210:15-3-19. Language arts for grade 8 [AMENDED]
210:15-3-20. Language arts for grade 9 [AMENDED]
210:15-3-21. Language arts for grade 10 [AMENDED]
210:15-3-22. Language arts for grade 11 [AMENDED]
210:15-3-23. Language arts for grade 12 [AMENDED]

AUTHORITY:
70 O. S. § 3-104, State Board of Education

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N/A

INCORPORATION BY REFERENCE:
N/A

ANALYSIS:
The proposed rule amendments revise the core curriculum to comply with the requirements set forth in 70 O. S. § 11-103.6(a) and to provide additional clarity and detail to the *Priority Academic Student Skills*.

CONTACT PERSON:
Connie Holland, 405-521-3308

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 O.S. 75, SECTION 308.1(A):

SUMMARY:
A committee composed of teachers, college instructors, professors, and business people worked together to make proposed revisions to the *Priority Academic Student Skills*, Oklahoma's core curriculum. The changes to the rules will provide additional clarity and detail to the existing rules. In addition, the revised *Priority Academic Student Skills* provide an alignment of skills from Pre-Kindergarten to Twelfth grade that will adequately prepare Oklahoma students with a smooth transition to college level work. The rules affected are writing, grammar, usage, and mechanics. Within the writing rules, changes will guide teachers in the writing process and types of writing to prepare students to be successful writers. The revisions to grammar, usage, and mechanics rules will enable students to build on skills from the Pre-Kindergarten level through twelfth grade in an incremental fashion that will enable students to be better readers and writers.

The intended effect of the rule changes is to comply with 70 O.S. § 11-103.6(a) and provide clear academic curriculum standards aligned to state assessments to ensure that all students are prepared for employment and/or postsecondary education (70 O.S. § 11-103.6). These changes will enable educators to have clear academic content standards from which to plan and implement. These rule changes are also in conformance with state law which states that each area of subject matter curriculum, except for technology curriculum, adopted by the State Board of Education for implementation by the beginning of the 2003-04 school year shall be thoroughly reviewed by the State Board every six (6) years according to and in coordination with the existing subject area textbook adoption cycle, and the State Board shall implement any revisions in such curriculum deemed necessary to achieve further improvements in the quality of education for the students of this state (70 O.S. § 11-103.6 (a).

[OAR Docket #10-775; filed 5-6-10]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 15. CURRICULUM AND INSTRUCTION

[OAR Docket #10-772]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 3. Priority Academic Student Skills
Part 3. Pre-Kindergarten and Kindergarten [AMENDED]
210:15-3-5.4. Mathematics for Pre-Kindergarten and Kindergarten [AMENDED]
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N/A
INCORPORATION BY REFERENCE:
N/A
ANALYSIS:
The proposed rule amendments will provide additional clarity and detail to the *Priority Academic Student Skills*, Oklahoma's core curriculum.
CONTACT PERSON:
Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2010:

SUBCHAPTER 3. PRIORITY ACADEMIC STUDENT SKILLS

PART 3. PRE-KINDERGARTEN AND KINDERGARTEN

210:15-3-5.4. Mathematics for Pre-Kindergarten and Kindergarten

(a) **Pre-Kindergarten.** Young children begin to develop mathematical understanding through experiences with a wide variety of real objects provided in learning centers and practical situations (e.g., blocks, pegs, buttons, cooking).

(1) Algebraic Reasoning: Patterns and Relationships - The student will sort and classify objects and analyze simple patterns.

(A) Sort and group objects into a set and explain verbally what the objects have in common (e.g., color, size, shape).

(B) Recognize patterns, repeat them, and explain them verbally.

(2) Number Sense - The child will understand the relationship between numbers and quantities.

(A) Begins to associate number concepts, vocabulary, quantities, and written numerals in meaningful ways.

(B) Begins to make use of one-to-one correspondence in counting objects and matching groups of objects.

(C) Develops increasing ability to count in sequence to ten.

(D) Counts objects in a set one-by-one from one through ten.

(E) Identifies and creates sets of objects one through ten.

(F) Identifies numerals one through ten.

(G) Recognizes the numerical value of sets of objects through ten.

(3) Geometry - The child will identify common geometric shapes and explore the relationship of objects in the environment.

(A) Recognize, describe, compare, and name common shapes (e.g., circle, square, rectangle).

(B) Demonstrate an understanding of directionality, order and position of objects, and words (e.g., on, under, above).

(4) Measurement - The child will explore the concepts of measurement.

(A) Linear Measurement.

(i) Measure objects using nonstandard units of measurement (e.g., pencil, paper clip, block).

(ii) Compare objects according to observable attributes (e.g., long, longer, longest; short, shorter, shortest; big, bigger, biggest; small, smaller, smallest; small, medium, large).

(iii) Compares and orders objects in graduated order (e.g., shortest to tallest, thinnest to thickest).

(B) Time. Develop an awareness of simple time concepts within his/her daily life (e.g., yesterday, today, tomorrow; morning, afternoon, night).

(5) Data Analysis - The child will collect, organize, and display data in a group setting.

(A) Begins to use numbers and counting as a means for solving problems and measuring quantity.

(B) Develops growing abilities to collect, describe, and record information through a variety of means, including discussion, drawings, maps, charts, and graphs.

(C) Describes similarities and differences between objects.

(~~a~~b) **Kindergarten.** Young children begin to develop mathematical understanding through experiences with a wide variety of real objects provided in learning centers and practical situations (e.g., blocks, pegs, buttons, cooking).

(~~b~~1) The **Major Concepts** should be taught in depth, using a variety of methods to help young children begin developing mathematical understanding through experiences with real objects in learning centers and practical situations. The major concepts are

(~~1~~A) Patterns - Repeating, Sorting

(~~2~~B) Number Sense - Counting to 10

(~~3~~C) Geometry and Spatial Sense - Shapes

(~~4~~D) Measurement - Comparisons

(~~5~~E) Data Analysis - Concrete Graphs

(~~c~~2) **Kindergarten suggested materials kit:** snap cubes, keys, fabric, macaroni, buttons, pattern blocks, children's books, counters, beans, bean sticks, dominoes, straws, containers, balance scales, rulers, coins, clocks, graph mats, painted beans or two-color counters

(~~1~~A) **Standard - ~~patterns~~algebraic reasoning: patterns and relationships.** The student will sort and classify objects and analyze simple patterns.

(~~A~~i) Sort and group objects into a set and explain verbally what the objects have in common (e.g., color, size, shape).

(~~B~~ii) Explain verbally and extend simple patterns (e.g., square, circle, square, circle).

(iii) Use objects to demonstrate "related facts" such as 3+4=7: 7-3=4: 7-4=3.

(~~2~~B) **Standard - number sense.** The student will understand the relationship between numbers and quantities.

(~~A~~i) Compare a group or set to another group, set, or numerical quantity and verbally explain which has more, less, or equivalent quantities.

(~~B~~ii) Pair and count objects using one-to-one correspondence (e.g., one napkin for each child at snack time).

(~~C~~iii) Count forward to twenty and backward from ten.

(~~D~~iv) Count objects in a set one-by-one from one through ~~ten~~twenty.

(~~E~~v) Identify and create sets of objects zero through ~~ten~~twenty.

(~~F~~vi) Identify and write numerals zero through ~~ten~~twenty, in and out of sequence. Children may still be reversing some numerals. ~~Identify the ordinal position (first through fifth) of objects.~~

(vii) Identify and use ordinal numbers to order objects first through tenth.

(~~G~~viii) Combine and remove objects from sets and verbally describe the result (e.g., adding objects to a set makes the set larger, subtracting objects from a set makes the set smaller).

(~~3~~C) **Standard - ~~geometry and spatial sense~~geometry.** The student will identify common geometric shapes and explore the relationship of objects in their environment.

(~~A~~i) ~~Identify, compare and draw basic two-dimensional geometric shapes (e.g., circle, square, triangle, rectangle).~~Identify, name, and describe a variety of basic two-dimensional geometric shapes such as squares, triangles, circles, rectangles, (regular) hexagons, and (isosceles) trapezoids, presented in a variety of ways (e.g., with different sizes or orientation).

(ii) Identify, name, and describe a variety of three-dimensional geometric shapes such as spheres, cubes, and cylinders.

(~~B~~iii) Model and use words indicating relative position or direction (e.g., students describe the relationships between self and objects in space using on, above, below, beside, under, on top of, behind, and over).

(~~4~~D) **Standard - measurement.** The student will explore the concepts of nonstandard and standard measurement.

(i) Linear measurement.

(~~A~~I) Measure objects using nonstandard units of measurement (e.g., pencil, paper clip, block, etc.).

(~~B~~II) Compare objects according to observable attributes (e.g., long, longer, longest; short, shorter, shortest; big, bigger, biggest; small, smaller, smallest; small, medium, large).

(~~C~~III) Compare and order objects in graduated order (e.g., shortest to tallest, thinnest to thickest).

(~~D~~IV) Identify the appropriate instrument used to measure length (ruler), weight (scale), time (clock: digital and analog; calendar: day, month, year, season), and temperature (thermometer).

(ii) Time.

(~~E~~I) Tell time on digital and analog clocks to the hour.

(~~F~~II) Identify the days of the week and months of the year.

(~~G~~iii) ~~Identify the coins:~~Money. Identify penny, nickel, dime and quarter.

(~~5~~E) **Standard - data analysis.** The student will collect and ~~analyze~~display data in a group setting.

(i) Data analysis.

(I) Use numbers and counting as a means for solving problems and measuring quantity.

(II) Develops abilities to collect, describe, and record information through a variety of means including discussion, drawings, maps, charts, and graphs.

(III) Describes similarities and differences between objects.

(~~A~~IV) Collect and analyze information about objects and events in the environment.

(~~B~~ii) Create and verbally explain a data display or graph (e.g., real object graph, pictorial graphs).

[OAR Docket #10-772; filed 5-6-10]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 20. STAFF

[OAR Docket #10-774]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 9. Professional Standards: Teacher Education and Certification
Part 1. General Teaching Certificate Requirements
210:20-9-10.1. Competency-based teacher licensure and certification system [AMENDED]
Part 17. Full (Subject Matter) Competencies for Licensure and Certification
210:20-9-172. Full (subject matter) competencies for licensure and certification [AMENDED]
Subchapter 11. Professional Standards: Accreditation Standards for Approved Teacher Education Programs
210:20-11-3. General education and professional education [AMENDED]
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The purpose of the rule amendments is to change the name technology education to technology engineering and to amend the competencies for licensure and certification.
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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2010:

SUBCHAPTER 9. PROFESSIONAL STANDARDS: TEACHER EDUCATION AND CERTIFICATION

PART 1. GENERAL TEACHING CERTIFICATE REQUIREMENTS

210:20-9-10.1. Competency-based teacher licensure and certification system

(a) Students admitted to a teacher education program on or after September 1, 1997, shall meet State Board of Education adopted competencies for licensure and certification as specified in Sections 210:20-9-152 and 210:20-9-172 of Title 210, OAC, and shall pass the applicable state competency examinations(s). Effective July 1, 1997, the available certificate areas under the competency based system are:

(1) art
(2) business education
(3) driver/safety education
(4) early childhood education
(5) elementary education
(6) English
(7) family and consumer sciences
(8) foreign languages
  (A) French
  (B) German
  (C) Latin
  (D) Russian
  (E) Spanish
  (F) other foreign language
(9) journalism
(10) library-media specialist
(11) mathematics
  (A) advanced/secondary (70 O.S. § 6-189.1)
    (i) analysis
    (ii) calculus
    (iii) trigonometry
  (B) intermediate--(Not required if teacher holds advanced mathematics certification)
    (i) algebra
    (ii) general math
    (iii) geometry

(12) middle level. Subject areas are:
(A) art
(B) English
(C) foreign language
(i) French
(ii) German
(iii) Latin
(iv) Russian
(v) Spanish
(vi) other foreign language
(D) mathematics (algebra/geometry)
(E) music
(F) physical education/health/safety
(G) science
(H) social studies
(I) technology ~~education~~engineering
(13) music
(A) instrumental/general music
(B) vocal/general music
(14) physical education/health/safety
(15) school psychometrist
(16) reading specialist
(17) ROTC (Reserve Officers Training Corps)
(18) school counselor
(19) school nurse
(20) school psychologist
(21) science
(A) biological sciences
(i) anatomy/physiology
(ii) biology
(iii) botany
(iv) zoology
(B) chemistry
(C) earth science
(D) physical science
(E) physics
(22) social studies
(A) United States History/Oklahoma History/Government/Economics
(B) World History/Geography
(C) Psychology/Sociology
(23) special education
(A) blind/visual impairment
(B) deaf/hard of hearing
(C) mild-moderate disabilities
(D) severe-profound/multiple disabilities
(24) speech/drama/debate
(25) speech-language pathologist
(26) vocational-technical education
(A) agricultural education
(B) marketing education
(C) technology ~~education~~engineering
(D) vocational business
(E) vocational family and consumer sciences
(27) Administrative
(A) Elementary Principal
(B) Middle Level Principal
(C) Secondary Principal
(D) Superintendent

(b) Competency for occupational agriculture, occupational family and consumer sciences, trade and industrial education, and vocational health occupations will be verified by passing a state or national licensure examination developed specifically to the occupation and/or occupational testing approved by the Oklahoma Department of Vocational and Technical Education. Non-degreed vocational teachers certified under rules promulgated by the State Board of Education are exempt from the provisions of 70 O.S. § 6-180 et. seq., except for those provisions concerning professional development programs.

PART 17. FULL (SUBJECT MATTER) COMPETENCIES FOR LICENSURE AND CERTIFICATION

210:20-9-172. Full (subject matter) competencies for licensure and certification

Full (subject matter) competencies are listed in (1) through (42) by subject/content area.

(1) **Art education.** The candidate for licensure and certification:

(A) Has a sound philosophical understanding of visual art education and is able to support, justify, and implement the visual art curriculum.

(B) Has an understanding of past, current, and future trends and issues in art education as well as art education research.

(C) Has a knowledge of developmentally appropriate visual art content including aesthetics, art criticism, and art history, around a core of art production.

(D) Has a working knowledge of and has had experience in integration of the arts with other fine arts areas as well as other academic disciplines.

(E) Understands and has experience in the application of the elements and principles of art and design.

(F) Understands art history including various styles, periods, ethnic groups, and cultures from around the world.

(G) Has a knowledge of aesthetics (the field of study that relates to beauty in the arts) and art criticism (art review and commentary), along with teaching strategies appropriate for both areas that involve a variety of media and awareness of developmental levels.

(H) Understands and has experience in various methods of art production and creative development including drawing, figure drawing, color and design, painting, printmaking, sculpture, clay, applied design, and technology. Additional experience should involve metal, stone, fiber, papermaking, wood, and mixed media.

(I) Has proficiency in teaching strategies that are developmentally appropriate and inclusive of various student learning styles and is sensitive to the needs

of diverse ethnic and cultural groups and those with disabilities.

(J) Develops a portfolio of his/her own artwork.

(K) Understands that contests and competitions have a valuable place in art education; however, they should not drive the development of the local curriculum.

(L) Has a knowledge of a wide variety of arts resources including community resources, materials, equipment, and information about exhibitions and/or major collections.

(M) Recognizes the important role of technology in education and that it may serve as a supportive tool in art education.

(N) Understands the art-related competencies in the Oklahoma core curriculum and knows how to incorporate them into various art classes.

(2) **Business education.** Competencies for business education are fulfilled by meeting competencies for vocational business.

(3) **Driver/safety education.** The candidate for licensure and certification:

(A) Applies, models, and teaches appropriate learning strategies for the safe operation of motor vehicles.

(B) Understands the social and emotional forces that influence the psychological makeup of young drivers and how these forces affect their driving behavior.

(C) Understands basic driving maneuvers including the universal concepts of defensive driving.

(D) Understands the physical laws of nature and the statutory laws that govern the safe operation of motor vehicles.

(E) Has an understanding of the basic mechanical systems that make up a motor vehicle and their influence on its operational limits.

(4) **Early childhood education (pre-kindergarten-third grade).** The competencies related to Early Childhood Education relate more specifically to the processes of learning and/or information processing than presentation of specific subject matter. The candidate for licensure and certification knows, understands, and uses:

(A) Factors that influence the development of young children, the sequence and interdependency of all areas, (i.e., physical, social, emotional, cognitive, and language) and uses that knowledge to meet the needs and characteristics of the group and individual children (birth to eight years of age) while respecting their unique rates of development.

(B) Positive child guidance strategies which help children learn to make responsible decisions regarding their own behavior and contributes to the development of self-control, self-motivation, and self-respect.

(C) The knowledge of how young children think, process information, and develop concepts in content areas including language, literacy, mathematics, science, health, safety, nutrition, social studies, art, music, drama, and movement.

(D) Integrative approaches (e.g., themes, topics, projects) to enable children to see and experience content areas and make meaningful connections to the child's life experience.

(E) Curriculum in regards to the children's needs and interests, as well as, developmentally appropriate skills and concepts.

(F) Developmentally appropriate strategies when planning, implementing, articulating, and evaluating (e.g., play, independent work, small group projects, group discussions, cooperative learning, open-ended questions, inquiry, and problem solving experiences.)

(G) A bias-free learning environment (indoors and outdoors) which is physically and psychologically safe for young children through the use of a balanced schedule, learning centers, and appropriate transitions and routine.

(H) Curriculum strategies, schedules, and the environment to meet the specific needs, interests, and experiences of all children with complex characteristics (i.e., adapting for those with disabilities, developmental delays, diverse cultures, or special abilities).

(I) Collaboration strategies regularly with families and other agencies in the community to enhance and support children's learning and development.

(J) Behaviors that recognize and respect diversity, how it influences learning, and builds connections among children's families, communities, and schools.

(K) Performance assessment (i.e., observation and documentation) and formal assessment to evaluate young children's development and learning for the purpose of planning appropriate and challenging programs, environments, and interactions and adapting for individual differences.

(L) Formative and summative evaluation measures to ensure comprehensive quality of the total program for children~~,~~ in reciprocal partnerships, with families, and the community.

(M) The historical, social, and ethical foundations of early childhood education which enables the teacher to articulate a philosophy and rationale for appropriate principles and practices.

(N) Self evaluation of teaching techniques and outcomes and modifies curriculum, strategies, schedules and environment to maximize the learning environment and enhance psychological safety for children.

(O) Knowledge to advocate for children by articulating to family, community and others the goals and methods used in the early childhood classroom.

(P) Instructional strategies/plans based on the Oklahoma core curriculum.

(Q) Understands and applies the following competencies in reading instruction as appropriate to the abilities of the student.

(i) Knows the stages of language development and the structure of the English language and alphabetic writing system including phonology, morphology, and orthography and their relationships to spelling and meaning.

(ii) Understands that primary language (oral) directly impacts the secondary languages (reading, writing, spelling). Knows and applies knowledge of implicit and explicit instruction in developing oral language. Knows the relationship of oral language to literacy.

(iii) Knows the developmental process of reading in order to assess, interpret, describe, develop appropriate instruction, monitor, reteach and reassess student's reading performance for concepts about print, phonological and phonemic awareness, phonics, spelling, word recognition, vocabulary, comprehension, fluency, and writing.

(iv) Identifies and applies all developmental levels of phonemic awareness to provide appropriate instruction in understanding words are made up of phonemes and that phonemes can be rearranged and manipulated to make different words that compose oral speech.

(v) Knows and provides appropriate systematic explicit and implicit phonological instruction for the application of spelling-sound correspondences for word analysis and for structural analysis for word recognition and word meaning development.

(vi) Knows and applies the relationships between spelling patterns and sounds of speech; knows how to support the student at each stage of spelling development; knows how to focus direct and indirect instruction to guide the student toward spelling proficiency.

(vii) Knows and applies knowledge of appropriate explicit and implicit instruction for vocabulary development (e.g., singular and plural).

(viii) Knows and applies strategies that promote comprehension and strategies to support children's understanding for the various elements of the different genres of text.

(ix) Knows and applies strategies and instructional approaches to support response to text and promote comprehension for literal, inferential, and critical/evaluative level (e.g., guided reading, literature and research circles).

(x) Knows and applies knowledge of instructional techniques to assist students with self-monitoring and self-corrections~~,~~ (i.e., semantics, syntax, and graphophonics).

(xi) Knows and applies the instructional strategies which contribute to the development of fluent reading.

(xii) Knows how to promote children's interest and engagement in reading and writing.

(R) Understands and applies the following competencies in mathematics instruction as appropriate to the abilities of the student.

(i) Builds on children's natural interest in mathematics and uses it to make sense of their physical and social worlds.

(ii) Establishes mathematics curriculum based on current knowledge of young children's cognitive, linguistic, physical and social-emotional development that builds on children's varying experiences.

(iii) Uses teaching practices that enhance children's problem-solving and reasoning processes which includes representing, communicating, and connecting mathematical ideas.

(iv) Understands that the curriculum should be coherent and compatible with known relationships and sequences of important mathematical ideas and that provides for children's deep and lasting interaction with key mathematical ideas.

(v) Introduces mathematical concepts, methods, and language through a variety of appropriate experiences and teaching strategies, including integrating mathematics with other activities and allowing ample time, materials and teacher support for children to explore and manipulate mathematical ideas.

(vi) Enhances children's mathematical knowledge, skills and strategies by providing an ongoing process of collecting information from multiple sources to determine a student's strengths and weaknesses in order to plan appropriate educational services.

(S) Understands and applies the following competencies in science instruction as appropriate to the abilities of the student.

(i) Plans an inquiry-based science program that develops a curriculum design to meet the interests, knowledge, understanding, abilities, and experiences of students in a framework of yearlong and short-term goals for students.

(ii) Selects teaching and assessment strategies that support the development of student understanding and encourage a community of science learners.

(iii) Guides and facilities learning through focused interaction with students, recognizes and responds to student diversity, and encourages and models the skills of inquiry in order for all students to participate in science learning.

(iv) Uses ongoing multiple methods and systematically gathers data about students understanding and abilities.

(v) Designs and manages learning environments that provide students with the time, space and resources needed for developing science skills.

(vi) Uses a variety of instructional strategies to implement an integrated/interdisciplinary curriculum and understands the interaction between the sciences and the process skills.

(T) Understands and applies the following competencies in social studies instruction as appropriate to the abilities of the student.

(i) Designs and manages learning environments that provide opportunities for students to exhibit traits of good citizenship in a variety of settings and situations.

(ii) Selects teaching and assessment strategies that support the development of student understanding of their community and culture.

(U) Understands and applies the following competencies in the use of technology as appropriate to the abilities of the student.

(i) Bases the use of technology on the knowledge of how young children think, process information and develop concepts in content areas.

(ii) Enhances children's cognitive and social abilities through the appropriate use of technology.

(iii) Integrates technology into the learning environment and uses it as one of many options to support children's learning.

(iv) Promotes equitable access to technology for all children and their families.

(v) Advocates in collaboration with parents for more appropriate technology applications for all children.

(5) **Elementary education.** The competencies developed in specific subject areas such as mathematics, art, science, etc., have been developed on a prekindergarten through 12th grade continuum. Because of this, it is unnecessary for the elementary education competencies to address anything more than the processes through which the subject matter competencies will be presented in the classroom. The candidate for licensure and certification:

(A) Understands his/her role and the variety of approaches to the organization of elementary schools.

(B) Understands the essential nature and importance of interaction and communication with students, parents, community members and colleagues.

(C) Models the role of the lifelong learner.

(D) Understands the role of the teaching profession in curriculum change and school improvement.

(E) Understands the link between child development, curriculum, and instruction.

(F) Understands and uses a variety of strategies to:

(i) select methods of assessment appropriate to each of the subject matter areas and to the age, development, and characteristics of students,

(ii) interpret and communicate assessment results accurately and ethically, and

(iii) integrate information gained from assessments into instructional plans.

(G) Has a knowledge of current research findings about teaching and learning.

(H) Analyzes his/her teaching practices through a variety of techniques.

(I) Understands appropriate classroom management systems and discipline practices.

(J) Understands the selection and use of materials, resources, and technology appropriate to individual differences.

(K) Creates an environment that facilitates learning experiences which make subject matter meaningful to students.

(L) Understands the subject matter areas common to the elementary curriculum and the integration of those subject matter areas.

(M) Facilitates learning groups as appropriate to the needs and/or interests of students and the goals of the lesson.

(N) Understands and applies the following competencies in reading instruction.

(i) Knows the stages of language development and the structure of the English language and alphabetic writing system including phonology, morphology, and orthography and their relationships to spelling and meaning.

(ii) Understands that primary language (oral) directly impacts the secondary languages (reading, writing, spelling). Knows and applies knowledge of implicit and explicit instruction in developing oral language. Knows the relationship of oral language to literacy.

(iii) Knows the developmental process of reading in order to assess, interpret, describe, develop appropriate instruction, monitor, reteach and reassess student's reading performance for concepts about print, phonological and phonemic awareness, phonics, spelling, word recognition, vocabulary, comprehension, fluency, and writing.

(iv) Identifies and applies all developmental levels of phonemic awareness to provide appropriate instruction in understanding words are made up of phonemes and that phonemes can be rearranged and manipulated to make different words that compose oral speech.

(v) Knows and provides appropriate systematic explicit and implicit phonological instruction for the application of spelling-sound correspondences for word analysis and for structural analysis for word recognition and word meaning development.

(vi) Knows and applies the relationships between spelling patterns and sounds of speech; knows how to support the student at each stage of spelling development; knows how to focus direct and indirect instruction to guide the student toward spelling proficiency.

(vii) Knows and applies knowledge of appropriate explicit and implicit instruction for vocabulary development, e.g., prefixes, suffixes and roots.

(viii) Knows and applies strategies that promote comprehension and strategies to support children's understanding for the various elements of the different genres of text.

(ix) Knows and applies strategies and instructional approaches to support response to text and promote comprehension for literal, inferential, and critical/evaluative level, e.g., guided reading, literature and research circles.

(x) Knows and applies knowledge of instructional techniques to assist students with self-monitoring and self-corrections, i.e., semantics, syntax, and graphophonics.

(xi) Knows and applies the instructional strategies which contribute to the development of fluent reading.

(xii) Knows how to promote children's interest and engagement in reading and writing.

(O) Understands interdisciplinary teaching and collaboration.

(P) Understands that all students can develop proficiencies in the Oklahoma core curriculum.

(6) **English.** The candidate for licensure and certification:

(A) Maintains current knowledge of content-area concepts of written and oral communication, literature, and language systems (phonetic, semantic, syntactic, pragmatic). For purposes herein, language systems and what they mean or include are:

(i) "Phonetic" means the letter/sound system of a particular language.

(ii) "Pragmatic" means the use of particular language and its conventions that convey meaning in a cultural context.

(iii) "Semantic" means the meaning system of a given language.

(iv) "Syntactic" means the structure, order, and organization of a given language.

(B) Applies comprehension, analysis, interpretation, synthesis and evaluation of auditory, written, and visual messages. For purposes herein, these terms have the following meaning and include:

(i) "Auditory messages" means spoken language, intonation.

(ii) "Visual messages" means visual graphics such as illustrations, pictures, photographs, symbols, and signs, body language, facial expressions.

(iii) "Written messages" means connected discourse, text.

(C) Applies appropriate learning strategies for reading, writing, studying, and researching.

(D) Communicates effectively in speaking and writing, using appropriate language conventions. For purposes herein, "language conventions" means grammar, figurative language, mechanics, specialized vocabulary, technical terms.

(E) Understands the influences of social and historical contexts and culture on language and literature and adapts instruction accordingly.

(F) Uses the understanding of language acquisition and language learning processes to develop student proficiencies and to modify instruction for second-language learners.

(G) Establishes a reflective and creative learning environment.

(H) Uses a variety of assessment strategies to evaluate student proficiencies in the language arts and to modify instruction appropriately.

(I) Uses technology to accomplish professional goals and to develop student's literacy proficiencies.

(J) Understands and teaches strategies appropriate to a variety of forms (genres), text organizations, and structures, including functional print and informational print. For purposes herein:

(i) "Functional print" means environmental print messages (i.e., signs, logos, labels, directions);

(ii) "Genre" means a particular type of literature (i.e., short story, novel, poem, essay, drama)

(iii) "Informational print" includes reference materials, telephone books, almanacs, dictionaries.

(K) Understands the literacy process (i.e., reading process and writing process), and provides effective instruction in literacy skills and strategies.

(L) Understands, teaches, and implements Oklahoma's core curriculum.

(7) **Family and consumer sciences.** Competencies for family and consumer sciences are fulfilled by meeting competencies for vocational family and consumer sciences.

(8) **Foreign languages.** The candidate for licensure and certification will possess competencies as specified in (A) through (G).

(A) Listening (K-12). The candidate for licensure and certification:

(i) Understands main ideas and supporting details of oral presentations and conversations (e.g., prepared speeches, news broadcasts, interviews, short lectures).

(ii) Understands spontaneous speech on a variety of basic topics.

(iii) Comprehends sustained conversation or narrative of general topics (secondary only).

(B) Speaking (K-12). The candidate for licensure and certification:

(i) Narrates and describes events, objects, and activities with supporting details.

(ii) Participates in spontaneous, face-to-face conversation involving more complicated skills and social situations, such as elaborating, apologizing, debating.

(iii) Initiates, sustains, and closes a general conversation.

(iv) Displays some ability to support opinions, explain in detail, and make assumptions (secondary only).

(v) Uses varied strategies, such as paraphrasing or restating, to facilitate communication in the language being studied (secondary only).

(C) Reading (K-12). The candidate for licensure and certification:

(i) Reads authentic (from the culture of the language studied) materials, such as selected short stories, poetry, and other literary works, articles, personal correspondence, and simple technical material written for the general reader.

(ii) Comprehends facts in authentic (from the culture of the language studied) texts and materials and makes appropriate inferences.

(iii) Comprehends authentic (from the culture of the language studied) communications via various media and technology.

(D) Writing (K-12). The candidate for licensure and certification:

(i) Communicates by writing simple facts and ideas.

(ii) Expresses narratives and descriptions of a factual nature.

(iii) Writes professional and social correspondence (secondary only).

(E) Culture (K-12). The candidate for licensure and certification:

(i) Is knowledgeable about the products of the culture of the language being taught.

(ii) Is knowledgeable about practices of the culture of the language being taught.

(iii) Is able to compare and contrast local culture and cultures of the language being taught.

(F) Second language acquisition (K-12). The candidate for licensure and certification:

(i) Is knowledgeable about first language development and its relation to second language learning.

(ii) Is knowledgeable about varied teaching approaches, methods, and strategies.

(iii) Is knowledgeable about varied second language assessment strategies and techniques that are developmentally appropriate.

(G) The Oklahoma core curriculum (K-12). The candidate for licensure and certification:

(i) Understands Oklahoma's core curriculum for languages, and

(ii) Implements the skills and knowledge appropriate to the level(s) taught.

(9) **Journalism.** The candidate for licensure and certification:

(A) Maintains current knowledge of concepts, theories, and practical application of such in the field of journalism, including those associated with print media, news gathering, writing, research, graphic design, photography, technology, law, and ethics.

(B) Applies comprehension, analysis, interpretation, and evaluation of auditory, written, and visual communication. Projects can be created based on this knowledge, i.e., newspapers, yearbooks, magazines, or broadcasts.

(C) Applies appropriate learning strategies for research, writing, organization, editing, and presentation of written and visual messages to different audiences.

(D) Communicates effectively in oral presentation, written communication, and visual design.

(E) Understands the influence of social and historical context of culture on journalism and adapts instruction accordingly.

(F) Understands the impact and importance of cultural diversity on the communication process.

(G) Establishes a reflective and creative learning environment.

(H) Uses a variety of assessment strategies and teaching methods to encourage creativity, to inspire critical thinking to develop problem-solving techniques, and to establish and maintain excellence in all journalism pursuits.

(I) Uses technology to accomplish professional goals and to develop students' journalistic proficiencies in all aspects of the subject, including, but not limited to, desktop publishing, photojournalism, written communication, graphic design, and research.

(J) Understands and can teach strategies appropriate to a variety of journalistic areas, including print media, graphic arts, printing technology, broadcast media, electronic media, advertising, business management practices, public relations, and professional writing.

(K) Is prepared to teach students in the following areas:

(i) desktop publishing;

(ii) writing for print and electronic media;

(iii) editing;

(iv) photography and videography;

(v) graphic design and typography;

(vi) headline, preview, promotion, and caption writing.

(L) Is prepared to teach

(i) research skills;

(ii) interviewing;

(iii) ethics, law, and responsibilities of the press;

(iv) journalism history;

(v) television, video, radio and multimedia production;

(vi) staff management, organization and leadership techniques;

(vii) business management and accounting procedures.

(M) Is knowledgeable of professional resources, including state, regional, and national scholastic press

associations, workshops, conferences, contests, and publications.

(N) Understands the importance of effective verbal and visual communication skills.

(O) Understands the role of co-curricular and extracurricular activities in the development of student interests as an extension of classroom instruction.

(P) Understands, teaches, and implements Oklahoma's core curriculum.

(10) **Library-media specialist.** The candidate for licensure and certification:

(A) Defines a program of information literacy and integrates it into the curriculum

(B) Defines a school library media program emphasizing information problem-solving skills and integrates it into the curriculum.

(C) Motivates and guides students and faculty in recognizing literature as an essential base of cultural and practical knowledge and in reading for pleasure as well as for information.

(D) Communicates effectively with students, faculty, staff, administrators, parents, other colleagues, and the general public by the ability to:

(i) exhibit communication skills necessary for collaborative planning with teachers.

(ii) develop and implement an effective public relations program to communicate library media program goals, needs, and accomplishments.

(E) Applies basic principles of evaluating and selecting resources and equipment to support the educational goals of the school by the ability to:

(i) develop selection policies which reflect curricular and instructional objectives, and informational and recreational needs of students and teachers.

(ii) develop criteria for evaluating and selecting specific print and non-print materials and equipment.

(iii) develop a collection of bibliographic aids, tools, and other sources to obtain current reviews and information about materials and equipment.

(iv) develop and implement procedures for preview, evaluation, selection, and acquisition of materials and equipment consistent with the district policy.

(v) reevaluate and maintain materials and equipment.

(F) Uses resources to support the personal, developmental, and curricular needs of students, and the instructional development needs of the faculty by the ability to:

(i) use a variety of ways to access information, including the use of new technologies.

(ii) provide specific information and resources in response to reference requests and recommend resources which support the curriculum.

(iii) conduct programs that include guidance in reading, listening, and viewing experiences.

(iv) assist students and staff in identifying, obtaining, using and/or producing media in appropriate formats for specific learning objectives.

(v) supervise students and staff in media production and equipment operation.

(vi) advocate resource-based learning through work with other faculty to identify appropriate instructional strategies and creative uses of resources.

(G) Recognizes the value of new technologies for information and instruction and assists faculty and students in their use by the ability to:

(i) recognize the importance of technological advancement to the education process.

(ii) demonstrate an understanding of the basic concepts, terminology, and applications of emerging technology.

(iii) recognize curricular implications that result from emerging technology and educational trends.

(iv) provide leadership in incorporating innovations into education.

(v) identify sources of information related to technological advancements.

(vi) provide technical advice and services for educational access to technology.

(H) Implements policies and procedures for effective and efficient acquisition, cataloging, processing, circulating, and maintaining equipment and resources to ensure access by the ability to:

(i) classify and catalog all print and nonprint media according to professionally accepted systems.

(ii) organize and maintain a current catalog and shelf list of all media.

(iii) implement procedures for initial processing, circulation, maintenance, service, and inventory of equipment and materials.

(I) Develops, implements, and evaluates school library media programs, including management of personnel, resources, and facilities by the ability to:

(i) assess the informational and instructional needs of students and faculty.

(ii) establish short- and long-range goals based on identified needs, the goals and objectives of the school district, state and national guidelines, and research findings.

(iii) prepare, justify, and administer a library media program budget.

(iv) prepare plans for new or renovated library media facilities.

(v) develop policies that assure optimum use of materials, equipment, facilities, and staff to support the curriculum.

(vi) train, supervise, and evaluate support staff, volunteers, and student helpers.

(vii) apply federal and state laws pertaining to media including those regarding copyright, privacy, and access to materials.

(viii) prepare statistical records and written reports.

(ix) assess and implement the use of new technologies for library media center management, educational applications, and information retrieval.

(x) evaluate the library media program based on established goals and standards.

(xi) apply effective management principles.

(xii) advocate, initiate, and implement agreements for resource sharing.

(J) Serves as a learning facilitator within schools and as a leader of faculty, administration, and students in the development of effective strategies for teaching and learning with the ability to:

(i) teach traditional and electronic skills in the retrieval, evaluation, and utilization of information to enable students to become independent learners.

(ii) plan and implement professional development programs.

(K) Demonstrates a commitment to professionalism by the ability to:

(i) exhibit comprehension of the roles, interrelationships, and interdependency of all types of libraries and information agencies.

(ii) exhibit an understanding of the role of the school library media program as a central element in the intellectual life of the school.

(iii) demonstrate a commitment to promoting intellectual freedom.

(iv) demonstrate professional integrity through ethical behavior.

(v) apply appropriate research findings and conduct action research to improve the library media program.

(vi) develop selection criteria that reflect relevant theories of learning and instruction.

(vii) apply basic principles of instructional design in producing resources for specified learning goals or objectives.

(11) **Elementary mathematics.**

(A) **Overview.** The goal of teacher preparation programs in mathematics, in partnership with common education, is to prepare future teachers for the twenty-first century. Teacher preparation programs must recognize the changes in society to prepare adaptive teachers who are capable of providing equitable schooling for all students of the twenty-first century. Teacher preparation programs must recognize that learning to teach effectively does not consist solely of acquiring content skills. Theory alone cannot create an effective teacher. Effective teaching also must include the processes or pedagogy of teaching that incorporate actual experiences with students and other teacher candidates within a body or bodies of knowledge. Teacher preparation programs are challenged with providing a rigorous body of content which is not isolated from the strategies of teaching and the application of that content.

(B) **Commitment.** The candidate for licensure and certification recognizes the individuality and worth of each student, believes that all students can learn and apply mathematics, and demonstrates these beliefs in practice.

(C) **Knowledge of students, mathematics and teaching.** The candidate for licensure and certification:

(i) Uses knowledge of child development and knowledge about the effects of this development on the learning of mathematics to guide curricular and instructional decisions. This will include primary, intermediate, and middle level philosophy, structure, organization, and child development.

(ii) Understands students' environment and cultural background, individual learning differences, student attitudes and aspirations, and community expectations and values on the learning of their students.

(iii) Has a broad and deep knowledge of the concepts, principles, techniques, and reasoning methods of mathematics that is used to set curricular goals and shape teaching.

(iv) Understands significant connections among mathematical ideas and the applications of these ideas to problem-solving in mathematics, in other disciplines, and in the world outside of school.

(v) Has experiences with practical applications of mathematical ideas and is able to incorporate these in their curricular and instructional decisions.

(vi) Is proficient in, at least, the mathematics content needed to teach the mathematics skills described in Oklahoma's core curriculum from multiple perspectives. This includes, but is not limited to, a concrete and abstract understanding of number systems and number sense, geometry, measurement, statistics and probability, functions, and algebra necessary to effectively teach the mathematics content skills addressed in the first through eighth grade as well as the mathematics process skills of problem-solving, reasoning, communication, and connections.

(vii) Is proficient in the use of a variety of instructional strategies to include, but not limited to, cooperative learning, use of concrete materials, use of technology (i.e., calculators and computers), and writing strategies to stimulate and facilitate student learning.

(viii) Is proficient in the design of instructional units which incorporate the mathematical processes of problem-solving, reasoning, communication, and connections into the instruction of content skills.

(ix) Has knowledge of how to teach and use this knowledge to make curriculum decisions, design instructional strategies and assessment plans, and choose materials and resources for mathematics instruction.

(x) Stimulates and facilitates student learning by using a wide range of formats, strategies, technologies, and procedures, and assuming a variety of roles to guide students' learning of mathematics.

(xi) Helps students learn mathematics by creating a safe and positive environment in which they take responsibility for learning.

(xii) Develops students' abilities to reason and think mathematically, to investigate and explore patterns, to discover structures and relationships, to formulate and solve problems, and to justify and communicate conclusions.

(xiii) Employs a range of formal and informal assessment methods to evaluate student learning in light of well-defined goals. Results should be used to guide the teaching process and provide opportunities for students to reflect on the strengths and weaknesses of individual performance.

(D) **Reflection and growth.** The candidate for licensure and certification:

(i) Regularly reflects on what one teaches and how one teaches.

(ii) Keeps informed of changes in mathematics and in the teaching of mathematics, continually seeking to improve his/her knowledge and practice.

(iii) Supports the involvement of families in their children's education, helps the community understand the role of mathematics and mathematics instruction in today's world, and, to the extent possible, involves the community in support of instruction.

(iv) Collaborates with peers and other education professionals to strengthen their school's programs, advance knowledge, and contribute to improving practice within the field.

(12) **Intermediate mathematics.**

(A) Overview. The goal of teacher preparation programs in mathematics, in partnership with common education, is to prepare future teachers for the twenty-first century. Teacher preparation programs must recognize the changes in society to prepare adaptive teachers who are capable of providing equitable schooling for all students of the twenty-first century. Teacher preparation programs must recognize that learning to teach effectively does not consist solely of acquiring content skills. Theory alone cannot create an effective teacher. Effective teaching also must include the processes or pedagogy of teaching that incorporate actual experiences with students and other teacher candidates within a body or bodies of knowledge. Teacher preparation programs are challenged with providing a rigorous body of content which is not isolated from the strategies of teaching and the application of that content.

(B) Commitment. The candidate for licensure and certification recognizes the individuality and worth of each student, believes that all students can learn and apply mathematics, and incorporates these beliefs into practice.

(C) Knowledge of students, mathematics and teaching. The candidate for licensure and certification:

(i) Has an understanding of middle level philosophy, structure, organization, and child development as well as an understanding of secondary level structure and child development.

(ii) Uses knowledge of child development and knowledge about the effects of this development on the learning of mathematics to guide curricular and instructional decisions.

(iii) Understands students' environment and cultural background, individual learning styles, student attitudes and aspirations, and community expectations and values on the learning of students.

(iv) Has a broad and deep knowledge of the concepts, principles, techniques, and reasoning methods of mathematics that is used to set curricular goals and shape teaching.

(v) Understands significant connections among mathematical ideas and the applications of these ideas to problem-solving in mathematics, in other disciplines, and in the world outside of school.

(vi) Has experiences with practical applications of mathematical ideas and is able to incorporate these in curricular and instructional decisions.

(vii) Is proficient in, at least, the mathematics content needed to teach the mathematics skills described in Oklahoma's core curriculum from multiple perspectives. This includes, but is not limited to, a concrete and abstract understanding of number systems and number theory, geometry and measurement, statistics and probability, functions, algebra, discrete mathematics, and calculus necessary to effectively teach the mathematics skills addressed in the sixth through eighth grade as well as the core and extended core skills in the algebra, geometry, functions, statistics, and probability sections of grades 9-12 in Oklahoma's core curriculum. This would also include the process skills and core skills addressed in the trigonometry and calculus sections of grades 9-12 in the Oklahoma core curriculum.

(viii) Is proficient in the use of a variety of instructional strategies to include, but is not limited to, cooperative learning, use of concrete materials, use of technology (i.e., calculators and computers), and writing strategies to stimulate and facilitate student learning.

(ix) Is proficient in the design of instructional units which incorporate the mathematical processes of problem-solving, reasoning, communication, and connections into the instruction of content skills.

(x) Has knowledge of how to teach and uses this knowledge in making curriculum decisions, designing instructional strategies and assessment plans, and choosing materials and resources for mathematics instruction.

(xi) Helps students learn mathematics by creating a safe and positive environment in which they take responsibility for learning.

(xii) Uses content knowledge and pedagogy to develop students' abilities to reason and think mathematically, to investigate and explore patterns, to discover structures and relationships, to formulate and solve problems, and to justify and communicate conclusions.

(xiii) Employs a range of formal and informal assessment methods to evaluate student learning in light of well-defined goals. Results should be used to guide the teaching process and provide opportunities for students to reflect on the strengths and weaknesses of individual performance.

(D) Reflection and growth. The candidate for licensure and certification:

(i) Keeps informed of changes in mathematics and in the teaching of mathematics, continually seeking to improve knowledge and practice. He/she regularly reflects on what is taught and how it is taught.

(ii) Supports the involvement of families in their children's education, helps the community understand the role of mathematics and mathematics instruction in today's world, and, to the extent possible, involves the community in support of instruction.

(iii) Collaborates with peers and other education professionals to advance knowledge and contribute to improving practice within the field.

(13) **Advanced/secondary mathematics.**

(A) Overview. The goal of teacher preparation programs in mathematics, in partnership with common education, is to prepare future teachers for the twenty-first century. Teacher preparation programs must recognize the changes in society to prepare adaptive teachers who are capable of providing equitable schooling for all students of the twenty-first century. Teacher preparation programs must recognize that learning to teach effectively does not consist solely of acquiring content skills. Theory alone cannot create an effective teacher. Effective teaching also must include the processes or pedagogy of teaching that incorporate actual experiences with students and other teacher candidates within a body or bodies of knowledge. Teacher preparation programs are challenged with providing a rigorous body of content which is not isolated from the strategies of teaching and the application of that content.

(B) Commitment. The candidate for licensure and certification recognizes the individuality and worth of each student, believes that all students can learn and apply mathematics, and incorporates these beliefs into practice.

(C) Knowledge of students, mathematics and teaching. The candidate for licensure and certification:

(i) Has an understanding of the middle level philosophy, structure, organization, and child development as well as an understanding of the secondary level structure and child development.

(ii) Uses knowledge of child development and knowledge about the effects of this development on the learning of mathematics to guide curricular and instructional decisions.

(iii) Understands students' environment and cultural background, individual learning styles, student attitudes and aspirations, and community expectations and values on the learning of students.

(iv) Has a broad and deep knowledge of the concepts, principles, techniques, and reasoning methods of mathematics that is used to set curricular goals and shape teaching.

(v) Understands significant connections among mathematical ideas and the applications of these ideas to problem solving in mathematics, in other disciplines, and in the world outside of school.

(vi) Has experiences with practical applications of mathematical ideas and is able to incorporate these in curricular and instructional decisions.

(vii) Is proficient in, at least, the mathematics content needed to teach the mathematics skills described in Oklahoma's core curriculum from multiple perspectives. This includes, but is not limited to, a concrete and abstract understanding of number systems and number theory, geometry and measurement, statistics and probability, functions, algebra, discrete mathematics, and calculus necessary to effectively teach the mathematics skills addressed in the sixth through twelfth grade in the Oklahoma core curriculum. (The depth and breadth of knowledge should be much greater than for the Intermediate Mathematics certification.)

(viii) Is proficient in the use of a variety of instructional strategies to include, but is not limited to, cooperative learning, use of concrete materials,

use of technology (i.e., calculators and computers), and writing strategies to stimulate and facilitate student learning.

(ix) Is proficient in the design of instructional units which incorporate the mathematical processes of problem-solving, reasoning, communication, and connections into the instruction of content skills.

(x) Has knowledge of how to teach and uses this knowledge in making curriculum decisions, designing instructional strategies and assessment plans, and choosing materials and resources for mathematics instruction.

(xi) Helps students learn mathematics by creating a safe and positive environment in which they take responsibility for learning.

(xii) Uses content knowledge and pedagogy to develop students' abilities to reason and think mathematically, to investigate and explore patterns, to discover structures and relationships, to formulate and solve problems, and to justify and communicate conclusions.

(xiii) Employs a range of formal and informal assessment methods to evaluate student learning in light of well-defined goals. Results should be used to guide the teaching process and provide opportunities for students to reflect on the strengths and weaknesses of individual performance.

(D) Reflection and growth. The candidate for licensure and certification:

(i) Keeps informed of changes in mathematics and in the teaching of mathematics, continually seeking to improve knowledge and practice. He/she regularly reflects on what is taught and how it is taught.

(ii) Supports the involvement of families in their children's education, helps the community understand the role of mathematics and mathematics instruction in today's world, and, to the extent possible, involves the community in support of instruction.

(iii) Collaborates with peers and other education professionals to advance knowledge and contribute to improving practice within the field.

(14) **Middle level personnel.** The competencies developed here focus on middle level philosophy, structure, organization, and student development. Subject matter competencies can be pulled from the K-12 competencies developed by the subject matter committees. The candidate for licensure and certification:

(A) Understands the history, philosophy, principles, structure, and organization of middle level education as it relates to early adolescence.

(B) Uses methods and materials for interdisciplinary instruction at the middle school level.

(C) Demonstrates an understanding of child-centered versus content-centered methodologies to meet the individual needs of middle level students.

(D) Has knowledge and skills pertaining to classroom management, organization, and student discipline at the middle school level.

(E) Understands the unique developmental characteristics and needs of the early adolescent, focusing on cognitive, physical, and social development.

(F) Establishes an environment using active participation to teach problem-solving and communication skills (reading, listening, writing, and speaking) as an integral part of all instruction.

(G) Understands curriculum-based teacher advisory programs, which foster character, responsibility, respect for others, and active community involvement.

(H) Understands the need to work collaboratively with other teachers, staff members, parents, resource persons, and community groups to enhance and support the education of young adolescents.

(I) Uses a variety of instructional strategies that address different learning styles to meet the needs of early adolescents.

(J) Models the role of the lifelong learner.

(K) Insures that all students develop proficiencies in the Oklahoma core curriculum.

(15) **Instrumental/general music.** The candidate for licensure and certification:

(A) Understands the basic philosophy of music education and is able to justify music within the school curriculum.

(B) Understands how music and fine arts experiences enhance student life experience and can promote music and the other arts in the community as well as within the school (including group motivational strategies and group management methods).

(C) Participates in ongoing professional development which includes involvement with professional associations and current experiences in performing endeavors.

(D) Has knowledge of effective methodologies and practices for encouraging self-analysis and musical independence.

(E) Has mastery of a major instrument, including appropriate techniques of breathing, embouchure (mouth position), posture, and hand position.

(F) Has a broad understanding of music history, including various styles and musical contributions of different cultural and ethnic groups.

(G) Has the ability to play an instrument(s) and teach a beginning instrumental music class, using current methods and quality music literature (collection of written music) for band, small ensemble, and solo.

(H) Is able to recognize and evaluate the sequential development of students, including those with disabilities.

(I) Has knowledge of where to locate printed musical resources and professional consultants.

(J) Has a working knowledge of how music integrates with all other academic disciplines, including other fine arts areas.

(K) Has the skill to collaborate and coordinate experiences with teachers of other academic disciplines, including other fine arts areas.

(L) Has competency in conducting techniques.

(M) Is able to teach basic fundamentals of embouchure (mouth position), hand position, technique and other related skills, of all the standard band and orchestra instruments at a basic Grade 6-8 level, including making a characteristic sound.

(N) Is able to sing a diatonic melody at sight, using a consistent sight-singing method, and the skill to teach that method appropriately at each grade level. "Diatonic" means relating to a musical scale having eight tones to the octave and using a fixed pattern of intervals without chromatic deviation.

(O) Is able to count rhythms using a consistent rhythm reading system and demonstrates the skill to teach that method appropriately at each grade level.

(P) Has knowledge of music education approaches such as Carl Orff, Zoltar Kodaly and Jaques-Dalcroze and is able to prepare and teach a lesson according to each of these approaches.

(Q) Has basic proficiency in piano, including a knowledge of keyboard harmony and is able to play functional progressions and simple accompaniments.

(R) Has the ability to use technology in the music classroom, such as basic knowledge of MIDI (musical instrument digital interface), sequencing and notational software programs, sound system set-up, and to make successful recordings of music ensembles.

(S) Understands basic laws of copyright pertaining to the correct use of copyrighted printed music and related responsibilities.

(T) Understands the competencies in General Music in Oklahoma's core curriculum and exhibits the skill to incorporate them into various instrumental music classes.

(16) **Vocal/general music.** The candidate for licensure and certification:

(A) Understands the basic philosophy of music education and is able to justify music within the school curriculum.

(B) Understands how music and fine arts experiences enhance student life experience and can promote music and the other arts in the community as well as within the school (including group motivational strategies and group management methods).

(C) Has knowledge of effective methodologies and practices for encouraging self-analysis and musical independence.

(D) Understands proper breathing techniques and tone production techniques.

(E) Has a knowledge of quality literature (collection of written music), both choral and solo, as well as folk songs appropriate for children.

(F) Understands the changing voice, both male and female.

(G) Has knowledge of where to locate professional consultants and printed music resources, such as music stores, music publisher catalogues,and textbook companies.

(H) Has a working knowledge of how to coordinate vocal music with all academic disciplines including other fine arts areas.

(I) Has proficiency in piano, including knowledge of scales, chords and the ability to warm up a choir and play simple accompaniments.

(J) Participates in ongoing professional development which includes involvement with professional associations.

(K) Has the ability to recognize and evaluate sequential musical development for all students, including those with disabilities.

(L) Has competency in conducting, including the ability to show musical nuance (subtle distinction or variation).

(M) Is able to prepare a series of lesson plans appropriate to each teaching level K-12.

(N) Has the ability to sing a diatonic melody at sight, using a consistent sight singing method and the skill to teach that method appropriately at each grade level. "Diatonic" means relating to a musical scale having eight tones to the octave and using a fixed pattern of intervals without chromatic deviation.

(O) Has the ability to count rhythms using a consistent rhythmic reading system and the skills to teach that method appropriately at each grade level.

(P) Has knowledge of the music education approaches such as Carl Orff, Zoltar Kodaly and Jaques-Dalcroze and is able to prepare and teach a lesson according to each of these approaches.

(Q) Has broad knowledge and understanding of music history including various styles, periods and cultures.

(R) Has broad knowledge and understanding of a variety of music and musical practices representative of different cultural and ethnic groups.

(S) Has the ability to use technology in the music classroom, such as basic knowledge of MIDI (musical instrument digital interface), sequencing and notational software programs, sound system set-up, and to make successful recordings of music ensembles.

(T) Understands basic laws of copyright pertaining to the correct use of copyrighted printed music and related responsibilities.

(U) Understands the competencies in General Music in Oklahoma's core curriculum and exhibits the skill to incorporate them into various vocal music classes.

(17) **Physical education/health/safety.** Competencies specified in both (A) Physical Education/Safety and (B) Health/Safety are required for licensure and certification:

(A) Physical education/safety. The candidate for licensure and certification:

(i) Understands the Oklahoma core curriculum and is able to develop instructional strategies/plans based on the Physical Education Section of the Oklahoma core curriculum.

(ii) Knows the developmental levels of growth and coordination of children (Grades K-12) and provides appropriate learning opportunities that support the physical and intellectual development of all students.

(iii) Understands and uses a variety of both psychomotor and cognitive assessment strategies to evaluate and modify the teaching/learning process.

(iv) Understands and utilizes physical education activities for curriculum integration.

(v) Applies movement concepts and principles to the learning and development of rhythm and motor skills for the following:

(I) locomotor movement

(II) nonlocomotor movement

(III) manipulative skills

(vi) Promotes participation and involvement in age-appropriate physical activities/sports suitable for lifelong participation in the following areas:

(I) lifetime activities/sports (i.e., skiing, camping, hiking, clogging)

(II) individual activities/sports (i.e., golf, tennis, self-defense, spelunking)

(III) nontraditional team activities/sports (i.e., korfball, lacrosse, square dancing)

(IV) traditional team activities/sports (i.e., basketball, volleyball, softball)

(vii) Understands adaptive learning activities for students with special needs.

(viii) Knows and can demonstrate appropriate fitness, wellness, and personal management components including:

(I) Fitness. Fitness includes: flexibility; muscular strength; cardiovascular fitness endurance; contraindicated exercises (traditional exercises which have been proven, through research, to be damaging to the body); nutrition.

(II) Wellness. Wellness encompasses: body composition; stress management; safety and accident prevention; designing and assessing personal fitness program; weight control; consumer education.

(III) Personal management skills: cooperation; sportsmanship; self-discipline; goal setting; following rules.

(ix) Uses information technology to enhance learning and to enhance personal productivity:

(I) Demonstrates knowledge of current technologies and their application in Physical Education.

(II) Designs, develops, and implements student learning activities that integrate information technology.

(III) Uses technologies to communicate, network, locate resources, and enhance continuing professional development.

(B) Health/safety. The candidate for licensure and certification:

(i) Communicates the concepts, purposes, and importance of health education; as evidenced by the following indicators:

(I) Describes the discipline of health education within the school setting.

(II) Describes the interdependence of health education and the other components of a coordinated school health program.

(III) Delivers accurate and up-to-date information about the most common comprehensive school health education components; including but not limited to: community and environmental health; consumer health; disease prevention and control; healthy communication; human growth and development; mental and emotional health; nutrition; personal health; safety and injury prevention; substance abuse.

(IV) Provides a rationale for health education, grades 1-12.

(V) Understands the variables that shape decisions about health behaviors.

(VI) Defines the role of the health education teacher within a coordinated school health program.

(VII) Explains the importance of health education.

(VIII) Identifies the kinds of school and community support necessary to implement a coordinated school health education program.

(IX) Understands the importance of ongoing professional development for health education teachers.

(X) Describes the importance of modeling positive, healthful behaviors.

(ii) Assesses the health education needs and interests of students.

(I) Uses information about health needs and interests of students.

(II) Recognizes behaviors that promote or compromise health.

(iii) Plans school health instruction.

(I) Selects realistic program goals and objectives.

(II) Identifies a scope and sequence plan for school health instruction.

(III) Plans health education lessons which reflect the abilities, needs, interests, developmental levels, and cultural backgrounds of students.

(IV) Describes effective ways to promote cooperation with and feedback from administrators, parents, and other community members.

(V) Determines procedures which are compatible with school policy for implementing curricula.

(VI) Develops activities to meet program goals and objectives based on the Health/Safety, and for grades 7-12, HIV/AIDS Prevention Education Sections of Oklahoma's core curriculum and on the National Health Education Standards.

(iv) Implements school health instruction.

(I) Employs a variety of strategies to facilitate implementation of a school health education curriculum; strategies include: provides a core health education curriculum; integrates health and other content areas; uses technology as a strategy to deliver health education; involves parents, guardians, or custodians of students in the teaching/learning process.

(II) Incorporates appropriate resources and materials including: selects valid and appropriate sources of information about health; uses school and community resources within a comprehensive program; refers students to valid and appropriate sources of health information.

(III) Employs appropriate strategies for dealing with health issues.

(IV) Adapts existing health education curricular models to community and student needs and interests.

(v) Evaluates the effectiveness of school health instruction.

(I) Uses appropriate criteria and methods unique to health education for evaluating student achievement.

(II) Interprets and applies student evaluation results to improve health instruction.

(18) **Psychometrist.** The candidate for licensure and certification:

(A) Understands and integrates into practice the philosophical, historical, and legal foundations of special education as applicable to the role of the psychometrist/educational diagnostician, in the following areas, including laws, regulations, and policies/procedures related to special education assessment, placement, and due process.

(B) Demonstrates knowledge, understanding, and application of ethical issues and standards of professional practice within the educational setting, in the following areas:

(i) ethical conduct and legal issues of the profession

(ii) role and function of the psychometrist/educational diagnostician

(iii) confidentiality

(iv) professional issues/standards

(v) training standards for particular instruments and procedures

(vi) continuing professional growth/development

(C) Demonstrates knowledge and skills in assessment, diagnosis, evaluation, and eligibility determination within the multidisciplinary team process for children with disabilities who may require special education services or early childhood intervention services, as follows:

(i) collection of assessment data for infants through school-age children, including the selection, administration, accurate scoring, and reporting of instruments and procedures appropriate to the areas of concern such as basic academic skills, cognitive/intellectual, developmental, perception, language, adaptive behavior, and classroom behavior

(ii) the adequacy, appropriate use, and limitations of assessment and evaluation instruments and procedures to be used by the psychometrist/educational diagnostician for educational purposes and recommendations

(iii) nondiscriminatory assessment strategies for culturally and linguistically diverse children

(D) Has knowledge and skills in effective communication and collaboration within the multidisciplinary team process, in the following areas:

(i) consultation for instructional interventions and problem-solving

(ii) educational recommendations and decision-making

(E) Understands and integrates into practice basic psychological foundations, including:

(i) cultural diversity

(ii) child and adolescent development

(iii) human exceptionalities

(iv) learning/educational psychology

(F) Understands and integrates into practice educational foundations, including:

(i) education of the exceptional learner

(ii) instructional and remedial techniques

(iii) the educational service delivery system

(19) **Reading specialist.** The candidate for licensure and certification shall possess the competencies specified in (A) through (D) of this paragraph:

(A) Reading philosophy and professional roles. Competencies are:

(i) Provides reading instructions so as to facilitate the process of reading development in which teacher and learner work together as members of a community of readers.

(ii) Has knowledge of the linguistic, dialectal, and developmental differences in readers that may affect instructional strategies.

(iii) Knows the principles and issues of major theories of language development as they relate to reading instruction.

(iv) Applies flexible approaches to reading instruction that recognize the uniqueness of individual students.

(v) Develops strategies for working with school staff, other reading specialists, and professionals within and beyond the school to foster reading development for individuals and groups.

(vi) Understands reading as a constructive process in which the experience of the reader, the text, and the requirements of the reading event interact in the creation of meaning.

(vii) Identifies appropriate interaction with staff members (e.g., content, special, classroom teachers) to facilitate reading development for all students.

(viii) Recognizes factors and procedures related to the involvement of parents and/or school and community groups at all stages of reader development.

(ix) Identifies and understands procedures involved in determining curriculum needs for reading programs.

(x) Identifies criteria and/or procedures involved in planning reading curriculum.

(xi) Identifies appropriate methods and resources related to the reading process for promoting professional growth for self and school staff.

(B) Instructional practices. Competencies are:

(i) Understands emergent literacy development and the types of experiences and concepts that support learning to read.

(ii) Applies knowledge of and provides appropriate instruction of graphophonemic relationships.

(iii) Understands the relationship among word knowledge (i.e., word attack and word recognition), reading fluency, and comprehension.

(iv) Identifies various word attack strategies (i.e., semantic clues, syntactic clues, graphophonemic clues), and various word recognition strategies (i.e., those that promote meaningful vocabulary growth).

(v) Provides appropriate instruction of strategies that promote comprehension at the literal, inferential, and critical/evaluative levels for both narrative and expository texts.

(vi) Understands the importance of adjusting reading strategies for different reading purposes.

(vii) Provides appropriate instruction of various techniques and study strategies (i.e., locating, organizing, and interpreting information).

(viii) Identifies content area reading strategies that activate and/or develop background knowledge.

(ix) Assists students in applying reading-related strategies to new learning situations.

(x) Understands the issues and procedures involved in teacher modeling, teacher-guided application, and independent practice.

(xi) Develops proficiencies in providing instruction associated with a variety of reading instructional approaches, including phonics, language experience, basal (basic) readers, and literature-based.

(xii) Implements cooperative learning strategies during reading instruction.

(xiii) Analyzes the strengths and weaknesses of the use of readability formulas in assessing instructional materials.

(xiv) Identifies appropriate criteria for selecting instructional materials (e.g., textbooks, reference books, computer software).

(xv) Analyzes issues and procedures involved in modifying curriculum to meet the needs of individual students.

(xvi) Recognizes the factors involved in organizing reading instruction to encourage individual student success.

(xvii) Promotes meaningful parent/guardian-child interaction related to reading.

(xviii) Creates a reading environment to increase student's motivation to read widely and independently and to promote reading as a lifelong habit.

(C) Reading diagnosis. Competencies are:

(i) Identifies factors that contribute to reading difficulties.

(ii) Understands the nature of reading difficulties (e.g., students' knowledge and strategies, factors embedded in the reading materials, instructional factors).

(iii) Implements, interprets, and uses informal and formal assessment and evaluation procedures for identifying and diagnosing reading difficulties (e.g., observation, criterion-referenced tests, norm-referenced tests, miscue analysis, informal reading inventories, anecdotal records).

(iv) Understands, analyzes, and creates case studies for diagnostic purposes.

(v) Identifies issues, procedures, and limitations involved in using oral diagnostic tests, silent diagnostic tests, visual and auditory screening, and observational diagnostic techniques.

(vi) Identifies activities and/or strategies appropriate for individual or group instruction for students with reading difficulty.

(D) Evaluation and assessment. Competencies are:

(i) Identifies characteristics, strengths, and weaknesses of formal and informal tests and instruments (i.e., criterion-referenced, norm-referenced, achievement tests, diagnostic tests, checklists, observations, and anecdotal records.)

(ii) Analyzes issues involved in the use of tests and other evaluation instruments for classification

or placement, diagnosis, or other evaluative purposes.

(iii) Selects tests or other instruments appropriate for a given evaluation purpose.

(iv) Understands the principles and/or procedures involved in the interpretation of test results.

(v) Identifies procedures for cooperating with various professionals in assessment, evaluation, and instructional planning for students with special needs.

(vi) Identifies criteria for evaluating reading programs.

(20) **Reserve Officers' Training Corps (ROTC).** Competency for ROTC certification will be verified by a recommendation from the appropriate ROTC Regional Headquarters.

(21) **School counselor.**

(A) The candidate for licensure and certification:

(i) Uses an understanding of human development to provide a comprehensive, developmental guidance and counseling program.

(ii) Understands the impact of environmental influences on students' development and achievement, and helps students develop strategies to resolve or cope with situations that may hinder learning.

(iii) Demonstrates an appreciation of human diversity by providing equitable guidance and counseling services for all students and by promoting a climate of mutual respect that helps students value themselves and others.

(iv) Uses effective leadership skills to plan, implement, and evaluate a comprehensive, developmental guidance and counseling program to address the needs of all students.

(v) Provides guidance and counseling services to address the needs and concerns of students and to help students develop skills to use in future situations.

(vi) Facilitates the educational and career development of individual students to help all students achieve success.

(vii) Uses formal and informal assessment to provide information about and to students, to monitor student progress, and to recommend changes to the student's educational environment.

(viii) Consults with parents and school personnel, provides professional expertise, and establishes collaborative relationships that foster a support system for students, parents, and the school community.

(ix) Establishes strong and positive ties with the home and the community to promote and support students' growth in school and beyond the school setting.

(x) Has knowledge of professional ethical codes, the importance of professional development, and the need to work with colleagues to advance the profession.

(B) Competency for School Counselor certification may also be verified by the Nationally Certified School Counselor (NCSC) credential.

(22) **School nurse.** Competency for School Nurse certification will be verified by a current registered nurse's license issued by the Oklahoma State Board of Nurse Registration and Nursing Education.

(23) **School psychologist.**

(A) The candidate for licensure and certification:

(i) Understands and integrates into practice the principles of professional school psychology, including:

(I) ethical conduct and legal issues

(II) confidentiality

(III) role and function of the school psychologist

(IV) service delivery models

(V) professional issues/standards

(VI) history and foundations

(VII) continuing professional growth/development

(ii) Demonstrates knowledge and skills in a comprehensive range of assessment, diagnosis, evaluation, and eligibility or intervention determination within the multidisciplinary team process, including:

(I) for children with disabilities who may require special education, early childhood intervention services, or other exceptional needs

(II) assessment for interventions

(III) collection of assessment data for infants through school-age children, including the selection, administration, accurate scoring, reporting, and interpretation of instruments and procedures appropriate to the areas of concern

(IV) the adequacy, appropriate uses, and limitations of assessment and evaluation instruments and procedures to be used by the school psychologist

(V) nondiscriminatory assessment strategies for culturally and linguistically diverse children

(iii) Demonstrates knowledge and skills in prevention, intervention, consultation, and counseling, including:

(I) behavioral and social skills

(II) cognitive/intellectual

(III) child developmental

(IV) academic learning/instructional

(V) mental health needs

(VI) crisis prevention/intervention

(iv) Demonstrates knowledge and skills in effective communication and collaboration, including:

(I) consultation for interventions and problem-solving

(II) recommendations and decision-making concerning educational and mental health needs of children

(III) working with families, children, professionals, and other service systems

(v) Demonstrates knowledge and application of statistics, research methodologies/designs, measurement, and program evaluation.

(vi) Understands and integrates into practice psychological foundations including:

(I) biological bases of behavior (developmental, neuropsychological, physiological, and other biological influences on behavior)

(II) social bases of behavior (social psychology and development)

(III) cultural diversity and cultural bases of behavior

(IV) child and adolescent development

(V) human exceptionalities and individual differences

(VI) human learning

(vii) Understands and integrates into practice educational foundations, including:

(I) education of the exceptional learner

(II) instructional and remediation techniques/intervention methods

(III) organization and operation of the schools

(IV) the educational and alternative service delivery systems

(B) Competency for School Psychologist certification may also be verified by the Nationally Certified School Psychologist (NCSP) credential.

(24) **Elementary science.** The candidate for licensure and certification:

(A) Is able to plan an inquiry-based science program for students using as a framework, Oklahoma's core curriculum. In doing this, one

(i) Develops a framework of yearlong and short-term goals for students.

(ii) Understands curriculum design to meet the interests, knowledge, understanding, abilities, and experiences of students.

(iii) Selects teaching and assessment strategies that support the development of student understanding and encourage a community of science learners.

(iv) Works with colleagues within and across disciplines and grade levels.

(B) Is able to guide and facilitate learning. In doing this, one

(i) Focuses and supports inquiries while interacting with students.

(ii) Facilitates discussion among students about scientific ideas.

(iii) Challenges students to accept and share responsibility for their own learning.

(iv) Recognizes and responds to student diversity and encourages all students to participate fully in science learning.

(v) Encourages and models the skills of scientific inquiry, as well as the curiosity, openness to new ideas and data, and questioning that characterizes science.

(C) Is able to engage in ongoing assessment of one's own teaching and of student learning. In doing this, one

(i) Uses multiple methods and systematically gathers data about student understanding and ability.

(ii) Analyzes assessment data to guide teaching.

(iii) Guides students in the evaluation of their work.

(iv) Uses student data, observations of teaching, and interaction with colleagues to reflect on and improve teaching practice.

(v) Uses student assessment information and classroom observation to report student achievement to students and parents.

(D) Is able to design and manage learning environments that provide students with the time, space, and resources needed for developing science skills. In doing this, one

(i) Structures the time so that students are able to engage in extended investigations.

(ii) Creates a setting for student work that is flexible and supportive of science inquiry.

(iii) Ensures a safe working environment.

(iv) Makes the available science tools, materials, media, and technological resources accessible to students.

(v) Identifies and uses resources outside the school.

(vi) Engages students in designing the learning environment.

(E) Is able to develop communities of science learners that reflect the intellectual rigor of scientific inquiry and the climate conducive to science learning. In doing this, one

(i) Respects the diverse needs, skills, and experiences of all students.

(ii) Enables students to have a significant voice in decisions about the content and context of their work and prepares students to take responsibility for learning.

(iii) Encourages collaboration among students.

(iv) Structures and facilitates ongoing formal and informal discussion based on a shared understanding of rules of scientific discourse.

(v) Models and emphasizes the skills and value of scientific inquiry.

(F) Is able to use a variety of instructional strategies to implement an integrated/ interdisciplinary curriculum.

(G) Is able to teach with a broad understanding of all content areas and to understand the interaction between the sciences and the process skills. Content areas and concepts within each are listed in subparagraphs (A) through (C) herein:

(i) Physical science content

(I) Properties of objects and materials

(II) Properties and changes of properties in matter

(III) Position and motion of objects

(IV) Motion and force

(V) Light, heat, electricity, and magnetism

(VI) Transfer of energy

(ii) Earth/space content

(I) Properties of earth materials

(II) Objects in the sky

(III) Changes in earth and sky

(IV) Structure of the earth system

(V) Earth's history

(VI) Earth in the solar system

(iii) Life science content

(I) The characteristics of organisms

(II) The life cycle of organisms

(III) Organisms and environment

(IV) Structure and function in living systems

(V) Reproduction and heredity

(VI) Regulation and behavior

(VII) Population and ecosystem

(VIII) Diversity and adaption of organisms

(H) Is able to develop conceptual understanding for science content using the process skills listed in Oklahoma's core curriculum, in Grades K through 8. Identified science concepts and/or science content areas are:

(i) System, order and organization

(ii) Constancy, change, equilibrium and measurement

(iii) Form and function

(iv) Abilities of technological design

(v) Abilities to distinguish between natural objects and objects made by humans

(vi) Understanding about science and technology

(vii) Science as a human endeavor

(viii) Nature of science

(ix) History of science

(x) Personal health

(xi) Characteristics and changes in populations

(xii) Population, resources, and environment

(xiii) Types of resources

(xiv) Natural hazards

(xv) Changes in environments

(xvi) Science and technology in local challenges

(xvii) Risk and benefits

(xviii) Science and technology in society

(25) **Earth science 6-12.** The candidate for licensure and certification:

(A) Is able to plan an inquiry-based science program for students using as a framework, Oklahoma's core curriculum. In doing this, one

(i) Develops a framework of yearlong and short-term goals for students.

(ii) Understands curriculum design to meet the interests, knowledge, understanding, abilities and experiences of students.

(iii) Selects teaching and assessment strategies that support the development of student understanding and encourage a community of science learners.

(iv) Works with colleagues within and across disciplines and grade levels.

(B) Is able to guide and facilitate learning. In doing this, one:

(i) Focuses and supports inquiries while interacting with students.

(ii) Facilitates discussion among students about scientific ideas.

(iii) Challenges students to accept and share responsibility for their own learning.

(iv) Recognizes and responds to student diversity and encourages all students to participate fully in science learning.

(v) Encourages and models the skills of scientific inquiry, as well as the curiosity, openness to new ideas and data, and questioning that characterizes science.

(C) Is able to engage in ongoing assessment of own teaching and of student learning. In doing this, one

(i) Uses multiple methods and systematically gathers data about student understanding and ability.

(ii) Analyzes assessment data to guide teaching.

(iii) Guides students in the evaluation of their work.

(iv) Uses student data, observations of teaching, and interaction with colleagues to reflect on and improve teaching practice.

(v) Uses student assessment information and classroom observation to report student achievement to students and parents.

(D) Is able to design and manage learning environments that provide students with the time, space, and resources needed for developing science skills. In doing this, one

(i) Structures the time so that students are able to engage in extended investigations.

(ii) Creates a setting for student work that is flexible and supportive of science inquiry.

(iii) Ensures a safe working environment.

(iv) Makes the available science tools, materials, media, and technological resources accessible to students.

(v) Identifies and uses resources outside the school.

(vi) Engages students in designing the learning environment.

(E) Is able to develop communities of science learners that reflect the intellectual rigor of scientific inquiry and the climate conducive to science learning. In doing this, one

(i) Respects the diverse needs, skills, and experiences of all students.

(ii) Enables students to have a significant voice in decisions about the content and context of their work and prepares students to take responsibility for learning.

(iii) Encourages collaboration among students.

(iv) Structures and facilitates ongoing formal and informal discussion based on a shared understanding of rules of scientific discourse.

(v) Models and emphasizes the skills, attitudes, and value of scientific inquiry.

(F) Is able to use a variety of instructional strategies to implement an integrated interdisciplinary curriculum.

(G) Is able to teach with a broad understanding of all content areas and understand the interaction between the sciences and the process skills. Identified Earth/Space Science content areas are:

(i) Structure of the earth system

(ii) Earth's history

(iii) Earth in the solar system

(iv) Energy in the Earth system

(v) Geochemical cycles

(vi) The universe and Earth's system

(H) Is able to develop conceptual understanding for science content using the process skills listed in Oklahoma's core curriculum, in Grades 6 through 12. Identified science concepts and/or science content areas are:

(i) System, order and organization

(ii) Evidence, models and explanation

(iii) Constancy, change, equilibrium and measurement

(iv) Form and function

(v) Abilities of technological design

(vi) Understanding about science and technology

(vii) Science as a human endeavor

(viii) Nature of science

(ix) Nature of scientific knowledge

(x) History of science

(xi) Historical perspectives

(xii) Personal health

(xiii) Personal and community health

(xiv) Population, resources, and environments

(xv) Population growth

(xvi) Natural hazards

(xvii) Natural resources

(xviii) Risks and benefits

(xix) Environmental quality

(xx) Natural and human induced hazards

(xxi) Science and technology in society

(xxii) Science and technology in local, national, and global challenges

(26) **Biological sciences 6-12.** The candidate for licensure and certification:

(A) Is able to plan an inquiry-based science program for students using as a framework, Oklahoma's core curriculum. In doing this, one:

(i) Develops a framework of yearlong and short-term goals for students.

(ii) Understands curriculum design to meet the interests, knowledge, understanding, abilities, and experiences of students.

(iii) Selects teaching and assessment strategies that support the development of student understanding and encourage a community of science learners.

(iv) Works with colleagues within and across disciplines and grade levels.

(B) Is able to guide and facilitate learning. In doing this, one:

(i) Focuses and supports inquiries while interacting with students.

(ii) Facilitates discussion among students about scientific ideas.

(iii) Challenges students to accept and share responsibility for their own learning.

(iv) Recognizes and responds to student diversity and encourages all students to participate fully in science learning.

(v) Encourages and models the skills of scientific inquiry, as well as the curiosity, openness to new ideas and data, and questioning that characterizes science.

(C) Is able to engage in ongoing assessment of own teaching and of student learning. In doing this, one:

(i) Uses multiple methods and systematically gathers data about student understanding and ability.

(ii) Analyzes assessment data to guide teaching.

(iii) Guides students in the evaluation of their work.

(iv) Uses student data, observations of teaching, and interaction with colleagues to reflect on and improve teaching practice.

(v) Uses student assessment information and classroom observation to report student achievement to students and parents.

(D) Is able to design and manage learning environments that provide students with the time, space and resources needed for developing science skills. In doing this, one:

(i) Structures the time so that students are able to engage in extended investigations.

(ii) Creates a setting for student work that is flexible and supportive of science inquiry.

(iii) Makes the available science tools, materials, media, and technological resources accessible to students.

(iv) Engages students in designing the learning environment.

(E) Is able to develop communities of science learners that reflect the intellectual rigor of scientific inquiry and the climate conducive to science learning. In doing this, one:

(i) Respects diverse needs, skills, and experiences of all students.

(ii) Enables students to have a significant voice in decisions about the content and context of their work and prepares students to take responsibility for learning.

(iii) Encourages collaboration among students.

(iv) Structures and facilitates ongoing formal and informal discussion based on a shared understanding of rules of scientific discourse.

(v) Models and emphasizes the skills and value of scientific inquiry.

(F) Is able to use a variety of instructional strategies to implement an integrated interdisciplinary curriculum.

(G) Is able to teach with a broad understanding of all content areas and understands the interaction between the sciences and the process skills. Identified Biological Sciences content areas are:

(i) Structure and function in living systems

(ii) Reproduction and heredity

(iii) Regulation and behavior

(iv) Population and ecosystem

(v) Diversity and adaption of organisms

(vi) The cell

(vii) The molecular basis of heredity

(viii) Biological adaptation

(ix) The interdependence of organisms

(x) Matter, energy, organization in living systems

(xi) Behavior of organisms

(H) Is able to develop conceptual understanding for science content using the process skills listed in Oklahoma's core curriculum, in Grades 6 through 12. Identified Science concepts and content areas are:

(i) System, order, and organization

(ii) Evidence, models, and explanation

(iii) Constancy, change, equilibrium, and measurement

(iv) Form and function

(v) Abilities of technological design

(vi) Understanding about science and technology

(vii) Science as a human endeavor

(viii) Nature of science

(ix) Nature of scientific knowledge

(x) History of science

(xi) Historical perspectives

(xii) Personal health

(xiii) Personal and community health

(xiv) Population, resources, and environments

(xv) Population growth

(xvi) Natural hazards

(xvii) Natural resources

(xviii) Risks and benefits

(xix) Environmental quality

(xx) Natural and human induced hazards

(xxi) Science and technology in society

(xxii) Science and technology in local, national, and global challenges

(27) **Physical sciences 6-12.** The candidate for licensure and certification:

(A) Is able to plan an inquiry-based science program for students using as a framework, Oklahoma's core curriculum. In doing this, one:

(i) Develops a framework of yearlong and short-term goals for students.

(ii) Understands curriculum design to meet the interests, knowledge, understanding, abilities, and experiences of students.

(iii) Selects teaching and assessment strategies that support the development of student understanding and encourage a community of science learners.

(iv) Works with colleagues within and across disciplines and grade levels.

(B) Is able to guide and facilitate learning. In doing this, one:

(i) Focuses and supports inquiries while interacting with students.

(ii) Facilitates discussion among students about scientific ideas.

(iii) Challenges students to accept and share responsibility for their own learning.

(iv) Recognizes and responds to student diversity and encourages all students to participate fully in science learning.

(v) Encourages and models the skills of scientific inquiry, as well as the curiosity, openness to new ideas and data, and questioning that characterizes science.

(C) Is able to engage in ongoing assessment of own teaching and of student learning. In doing this, one:

(i) Uses multiple methods and systematically gathers data about student understanding and ability.

(ii) Analyzes assessment data to guide teaching.

(iii) Guides students in the evaluation of their work.

(iv) Uses student data, observations of teaching, and interaction with colleagues to reflect on and improve teaching practice.

(v) Uses student assessment information and classroom observation to report student achievement to students and parents.

(D) Is able to design and manage learning environments that provide students with the time, space, and resources needed for developing science skills. In doing this, one:

(i) Structures the time so that students are able to engage in extended investigations.

(ii) Creates a setting for student work that is flexible and supportive of science inquiry.

(iii) Ensures a safe working environment.

(iv) Makes the available science tools, materials, media, and technological resources accessible to students.

(v) Identifies and uses resources outside the school.

(vi) Engages students in designing the learning environment.

(E) Is able to develop communities of science learners that reflect the intellectual rigor of scientific inquiry and the climate conducive to science learning. In doing this, one:

(i) Respects the diverse needs, skills, and experiences of all students.

(ii) Enables students to have a significant voice in decisions about the content and context of their work and prepares students to take responsibility for learning.

(iii) Encourages collaboration among students.

(iv) Structures and facilitates ongoing formal and informal discussion based on a shared understanding of rules of scientific discourse.

(v) Models and emphasizes the skills and value of scientific inquiry.

(F) Is able to use a variety of instructional strategies and use integrated and interdisciplinary curriculum.

(G) Is able to teach with a broad understanding of all content areas and understands the interaction between the sciences and the process skills. Identified Physical Science concepts and content areas are:

(i) Properties and changes of properties in matter

(ii) Motions and force

(iii) The structure of atoms

(iv) Structure and properties of matter

(v) Chemical reactions

(vi) Conservation of energy

(vii) Interactions of energy and matter

(viii) The earth system

(ix) The Universe

(H) Is able to develop conceptual understanding for science content using the process skills listed in Oklahoma's core curriculum, in Grades 6 through 12. Identified Science concepts and content areas are:

(i) System, order, and organization

(ii) Evidence, models, and explanation

(iii) Constancy, change, equilibrium, and measurement

(iv) Form and function

(v) Abilities of technological design

(vi) Understanding about science and technology

(vii) Science as a human endeavor

(viii) Nature of science

(ix) Nature of scientific knowledge

(x) History of science

(xi) Historical perspectives

(xii) Personal health

(xiii) Personal and community health

(xiv) Population, resources, and environments

(xv) Population growth

(xvi) Natural hazards

(xvii) Natural resources

(xviii) Risks and benefits

(xix) Environmental quality

(xx) Natural and human induced hazards

(xxi) Science and technology in society

(xxii) Science and technology in local, national, and global challenges

(28) **Chemistry 6-12.** The candidate for licensure and certification:

(A) Is able to plan an inquiry-based science program for students using as a framework, Oklahoma's core curriculum. In doing this, one:

(i) Develops a framework of yearlong and short-term goals for students.

(ii) Understands curriculum design to meet the interests, knowledge, understanding, abilities, and experiences of students.

(iii) Selects teaching and assessment strategies that support the development of student understanding and encourage a community of science learners.

(iv) Works with colleagues within and across disciplines and grade levels.

(B) Is able to guide and facilitate learning. In doing this, one:

(i) Focuses and supports inquiries while interacting with students.

(ii) Facilitates discussion among students about scientific ideas.

(iii) Challenges students to accept and share responsibility for their own learning.

(iv) Recognizes and responds to student diversity and encourages all students to participate fully in science learning.

(v) Encourages and models the skills of scientific inquiry, as well as the curiosity, openness to new ideas and data, and questioning that characterizes science.

(C) Is able to engage in ongoing assessment of own teaching and of student learning. In doing this, one:

(i) Uses multiple methods and systematically gathers data about student understanding and ability.

(ii) Analyzes assessment data to guide teaching.

(iii) Guides students in the evaluation of their work.

(iv) Uses student data, observations of teaching, and interaction with colleagues to reflect on and improve teaching practice.

(v) Uses student assessment information and classroom observation to report student achievement to students and parents.

(D) Is able to design and manage learning environments that provide students with the time, space, and resources needed for developing science skills. In doing this, one:

(i) Structures the time so that students are able to engage in extended investigations.

(ii) Creates a setting for student work that is flexible and supportive of science inquiry.

(iii) Ensures a safe working environment.

(iv) Makes the available science tools, materials, media, and technological resources accessible to students.

(v) Identifies and uses resources outside the school.

(vi) Engages students in designing the learning environment.

(E) Is able to develop communities of science learners that reflect the intellectual rigor of scientific inquiry and the climate conducive to science learning. In doing this, one:

(i) Respects the diverse needs, skills, and experiences of all students.

(ii) Enables students to have a significant voice in decisions about the content and context of their work and prepares students to take responsibility for learning.

(iii) Encourages collaboration among students.

(iv) Structures and facilitates ongoing formal and informal discussion based on a shared understanding of rules of scientific discourse.

(v) Models and emphasizes the skills and value of scientific inquiry.

(F) Is able to use a variety of instructional strategies and use integrated and interdisciplinary curriculum.

(G) Is able to teach with a broad understanding of all content areas and understands the interaction between the sciences and the process skills. Identified Chemistry concepts and content areas are:

(i) Structures and properties of matter

(ii) Chemical reactions

(iii) Transfer of energy

(iv) The structure of atoms

(v) Properties and changes of properties in matter

(H) Is able to develop conceptual understanding for science content using the process skills listed in Oklahoma's core curriculum, in Grades 6 through 12. Identified Science concepts and content areas are:

(i) System, order, and organization

(ii) Evidence, models, and explanation

(iii) Constancy, change, equilibrium, and measurement

(iv) Form and function

(v) Abilities of technological design

(vi) Understanding about science and technology

(vii) Science as a human endeavor

(viii) Nature of science

(ix) Nature of scientific knowledge

(x) History of science

(xi) Historical perspectives

(xii) Personal health

(xiii) Personal and community health

(xiv) Population, resources, and environments

(xv) Population growth

(xvi) Natural hazards

(xvii) Natural resources

(xviii) Risks and benefits

(xix) Environmental quality

(xx) Natural and human induced hazards

(xxi) Science and technology in society

(xxii) Science and technology in local, national, and global challenges

(29) **Physics 6-12.** The candidate for licensure and certification:

(A) Is able to plan an inquiry-based science program for students using as a framework, Oklahoma's core curriculum. In doing this, one:

(i) Develops a framework of yearlong and short-term goals for students.

(ii) Understands curriculum design to meet the interests, knowledge, understanding, abilities, and experiences of students.

(iii) Selects teaching and assessment strategies that support the development of student understanding and encourage a community of science learners.

(iv) Works with colleagues within and across disciplines and grade levels.

(B) Is able to guide and facilitate learning. In doing this, one:

(i) Focuses and supports inquiries while interacting with students.

(ii) Facilitates discussion among students about scientific ideas.

(iii) Challenges students to accept and share responsibility for their own learning.

(iv) Recognizes and responds to student diversity and encourages all students to participate fully in science learning.

(v) Encourages and models the skills of scientific inquiry, as well as the curiosity, openness to

new ideas and data, and questioning that characterizes science.

(C) Is able to engage in ongoing assessment of own teaching and of student learning. In doing this, one:

(i) Uses multiple methods and systematically gathers data about student understanding and ability.

(ii) Analyzes assessment data to guide teaching.

(iii) Guides students in the evaluation of their work.

(iv) Uses student data, observations of teaching, and interaction with colleagues to reflect on and improve teaching practice.

(v) Uses student assessment information and classroom observation to report student achievement to students and parents.

(D) Is able to design and manage learning environments that provide students with the time, space, and resources needed for developing science skills. In doing this, one:

(i) Structures the time so that students are able to engage in extended investigations.

(ii) Creates a setting for student work that is flexible and supportive of science inquiry.

(iii) Ensures a safe working environment.

(iv) Makes the available science tools, materials, media, and technological resources accessible to students.

(v) Identifies and uses resources outside the school.

(vi) Engages students in designing the learning environment.

(E) Is able to develop communities of science learners that reflect the intellectual rigor of scientific inquiry and the climate conducive to science learning. In doing this, one:

(i) Respects the diverse needs, skills, and experiences of all students.

(ii) Enables students to have a significant voice in decisions about the content and context of their work and prepares students to take responsibility for learning.

(iii) Encourages collaboration among students.

(iv) Structures and facilitates ongoing formal and informal discussion based on a shared understanding of rules of scientific discourse.

(v) Models and emphasizes the skills and value of scientific inquiry.

(F) Is able to use a variety of instructional strategies and use integrated and interdisciplinary curriculum.

(G) Is able to teach with a broad understanding of all content areas and understands the interaction between the sciences and the process skills. Identified Physics concepts and content areas are:

(i) Motions and forces

(ii) Conservation of energy

(iii) Transfer of energy

(iv) Interactions of energy and matter

(H) Is able to develop conceptual understanding for science content using the process skills listed in Oklahoma's core curriculum, in Grades 6 through 12. Identified Science concepts and content areas are:

(i) System, order, and organization

(ii) Evidence, models, and explanation

(iii) Constancy, change, equilibrium, and measurement

(iv) Form and function

(v) Abilities of technological design

(vi) Understanding about science and technology

(vii) Science as a human endeavor

(viii) Nature of science

(ix) Nature of scientific knowledge

(x) History of science

(xi) Historical perspectives

(xii) Personal health

(xiii) Personal and community health

(xiv) Population, resources, and environments

(xv) Population growth

(xvi) Natural hazards

(xvii) Natural resources

(xviii) Risks and benefits

(xix) Environmental quality

(xx) Natural and human induced hazards

(xxi) Science and technology in society

(xxii) Science and technology in local, national, and global challenges

(30) **Social Studies.**

(A) United States History/Oklahoma History/government/economics. The candidate for licensure and certification:

(i) Knows the major themes of United States history and their interrelatedness.

(ii) Understands how the political growth, major events, and individuals affected the development of the United States.

(iii) Examines and analyzes historical documents which contributed to the establishment and growth of the government of the United States.

(iv) Identifies and describes events, trends, individuals, and movements which shaped the social, economic, and cultural development of the United States.

(v) Analyzes events and identifies individuals who defined and continue to impact the role of the United States in world affairs.

(vi) Knows the roles and function of government and the foundations, structure, and function of American government.

(vii) Identifies and explains the rights and responsibilities of citizens of the United States.

(viii) Describes the characteristics of local and state governments and the national government,

and the relationships among the different levels of government.

(ix) Analyzes how the American political process works and the relationship of the process to the individual as a citizen of the state and the nation.

(x) Identifies and analyzes the events which led to Oklahoma's historical, political, economic, and cultural development.

(xi) Identifies important individuals and groups which have had an influence on Oklahoma's heritage.

(xii) Identifies the diverse geographic features and resources found in Oklahoma and describes their influence on Oklahoma's historical development and economy.

(xiii) Understands basic application of economic theories.

(xiv) Interprets economic trends in historical, political, and geographic contexts.

(xv) Analyzes the influence of the past on the present and uses a knowledge of history and government to anticipate and plan for the future, evaluating alternative courses of action.

(xvi) Applies the skills of analysis, interpretation, research, and decision-making to develop an understanding of history, government, and economic concepts.

(xvii) Knows the content of the Oklahoma core curriculum for United States History, Oklahoma History, government, and economics.

(B) World History/geography. The candidate for licensure and certification:

(i) Compares and contrasts differing sets of ideas, personalities, and institutions of world cultures and major historical periods.

(ii) Analyzes the cause and effect of relationships, multiple causation and perspectives, including the importance of the individual on historical events.

(iii) Analyzes the influence of the past on the present and uses a knowledge of history and geography to anticipate and plan for the future, evaluating alternative courses of action.

(iv) Interprets given historical data in order to evaluate information in its context.

(v) Knows the six elements of geographic organization: the world in spatial terms, places and regions, physical systems, human systems, environment and society, and application of geographic data, and applies them to developing an understanding of geography concepts.

(vi) Applies the skills of analysis, interpretation, research, and decision-making to develop an understanding of history and geographic concepts.

(vii) Knows the content of the Oklahoma core curriculum for World History and Geography.

(C) Psychology/sociology. The candidate for licensure and certification:

(i) Exhibits a basic intellectual grasp of psychological and sociological theories, vocabulary, history, and recent trends in the fields of psychology and sociology.

(ii) Understands basic concepts relative to social, developmental, abnormal and clinical psychology, learning theory (classical, operant, and cognitive), and other significant areas in the discipline of psychology, such as the scientific method.

(iii) Knows basic brain-based research and theory, and how biology and behavior interact.

(iv) Recognizes the differences among experimental, classical, and conditioning approaches to the study of psychology.

(v) Analyzes and interprets how today's psychologists view behavior in the following areas: the biological, the cognitive, the person-centered, and the psycho-dynamic perspectives.

(vi) Knows the theories and measurement of intelligence testing.

(vii) Knows basic concepts relative to group behavior, ethnicity, social mores, crime, demographics and current social issues.

(viii) Knows and analyzes culture, social structure, social stratification, social institutions, socialization, social movements, and social problems, as sociological concepts.

(ix) Knows and applies the basic sociological research processes, e.g., hypothesis formulations, sampling

(31) **Special Education (birth through twelfth grade).** For purposes of providing special education services and identifying competencies deemed necessary for licensure and certification, four areas of disabilities have been identified within the overall field of special education; these are Blind/Visual Impairment, Deal/Hard of Hearing, Mild-Moderate Disabilities, and Severe-Profound/Multiple Disabilities. Competencies identified at the early childhood level and deemed common to all areas of disabilities are addressed in (A) and apply to all candidates for licensure and certification in any area of special education. Additional competencies in each of the four areas listed above in this paragraph are addressed in (B) through (E).

(A) Competencies common to all areas of disabilities. The candidate for licensure and certification:

(i) Understands the historical, social, and ethical foundations; legal and regulatory; and current trends and issues of early childhood, early childhood special education, and special education.

(ii) Identifies specific/common disabilities in children and the implications for development and learning.

(iii) Plans and implements programming and curricula using current best practices and principles of early childhood education.

(iv) Understands typical and atypical development and the interdependency of all developmental areas, and respects each child's unique characteristics and their implications for learning.

(v) Demonstrates knowledge and skills in selection and administration of developmental screening, assessment, and evaluation instruments and methods which are comprehensive, nondiscriminatory for linguistic and cultural differences, formal and informal, and appropriate for children with early childhood disabilities.

(vi) Participates and collaborates with all team members in conducting the evaluation/assessment within the multidisciplinary team process.

(vii) Understands and demonstrates knowledge of the individualized family service plan (IFSP)/individualized education program (IEP) process by:

(I) using assessment results, in partnership with the family and other team members, to develop the IFSP/IEP

(II) monitoring IFSP/IEP progress

(viii) Understands and implements early childhood curricula by adapting educational strategies, schedules and environments (individual, group, home settings) to meet the specific needs, interests, and experiences of all children.

(ix) Understands and participates in the transition process across programs and service systems by:

(I) planning for and linking current developmental learning experiences and teaching strategies with those of the next educational setting

(II) communicating options for programs and services at the next level, while assisting the family in planning for transition.

(x) Develops and uses formative and summative program evaluation to ensure comprehensive quality of programs and services for children and their families.

(xi) Collaborates and consults regularly with families, other team members, and agencies to enhance and support children's learning and development by:

(I) assisting families in identifying resources, priorities, and concerns, and in accessing appropriate services

(II) respecting parents' choices and goals for their children

(III) implementing services for children and their families, consistent with laws, regulations, and procedural safeguards

(xii) Uses positive and supportive early childhood guidance, teaching, and behavioral strategies which help all children learn to make responsible decisions regarding their own behavior and contribute to the development of self-control, self-motivation, and self-worth.

(xiii) Demonstrates professionalism and ethical practice, including:

(I) advocacy on behalf of young children and their families to improve quality of programs and services for young children and for early childhood special education

(II) implementation of a professional development plan which incorporates best practices and principles.

(xiv) Understands and applies the following competencies in reading instruction.

(I) Knows the stages of language development and the structure of the English language and alphabetic writing system including phonology, morphology, and orthography and their relationships to spelling and meaning.

(II) Understands that primary language (oral) directly impacts the secondary languages (reading, writing, spelling). Knows and applies knowledge of implicit and explicit instruction in developing oral language. Knows the relationship of oral language to literacy.

(III) Knows the developmental process of reading in order to assess, interpret, describe, develop appropriate instruction, monitor, reteach and reassess student's reading performance for concepts about print, phonological and phonemic awareness, phonics, spelling, word recognition, vocabulary, comprehension, fluency, and writing.

(IV) Identifies and applies all developmental levels of phonemic awareness to provide appropriate instruction in understanding words are made up of phonemes and that phonemes can be rearranged and manipulated to make different words that compose oral speech.

(V) Knows and provides appropriate systematic explicit and implicit phonological instruction for the application of spelling-sound correspondences for word analysis and for structural analysis for word recognition and word meaning development.

(VI) Knows and applies the relationships between spelling patterns and sounds of speech; knows how to support the student at each stage of spelling development; knows how to focus direct and indirect instruction to guide the student toward spelling proficiency.

(VII) Knows and applies knowledge of appropriate explicit and implicit instruction for vocabulary development, e.g., prefixes, suffixes and roots.

(VIII) Knows and applies strategies that promote comprehension and strategies to support children's understanding for the various elements of the different genres of text.

(IX) Knows and applies strategies and instructional approaches to support response to

text and promote comprehension for literal, inferential, and critical/evaluative level, e.g., guided reading, literature and research circles.

(X) Knows and applies knowledge of instructional techniques to assist students with self-monitoring and self-corrections, i.e., semantics, syntax, and graphophonics.

(XI) Knows and applies the instructional strategies which contribute to the development of fluent reading.

(XII) Knows how to promote children's interest and engagement in reading and writing.

(B) Blind/visual impairment. The candidate for licensure and certification:

(i) Understands the philosophical, historical, and legal foundations of special education for students with visual impairment including.

(I) trends and issues in special education

(II) special education policies and procedures

(III) laws and regulations regarding special education

(ii) Demonstrates knowledge of characteristics of students with visual impairments.

(iii) Demonstrates knowledge and skills in assessment, diagnosis, evaluation, and eligibility determination within the multidisciplinary team process for students with visual impairments including:

(I) procedures relevant to the impact of specific visual disorders on learning and experience, as well as procedures used for screening, prereferral, referral, and identification of students with visual impairments:

(II) vision screening methods

(III) functional vision assessment

(IV) learning media assessment

(V) orientation and mobility

(VI) independent living skills

(VII) vocational skills

(VIII) assistive technology

(IX) recreation and leisure skills

(X) classroom observation

(iv) Understands and demonstrates knowledge of the individualized education programs (IEP) process by:

(I) using assessment results, in partnership with team members, to develop the IEP

(II) monitoring IEP progress

(v) Demonstrates knowledge and skills to plan and implement appropriate and effective individualized education programs for students with visual impairments, based upon knowledge of subject matter and adaptation of curriculum and materials to meet individual abilities and sensory, conceptual and communication needs, including:

(I) social interaction skills

(II) recreation and leisure skills

(III) use of assistive technology

(IV) prerequisite skills and concepts for orientation and mobility instruction

(V) independent living skills

(VI) career education

(VII) visual efficiency skills

(VIII) literacy skills

(IX) organizational skills

(vi) Plans and manages supportive educational environments relative to the student's specific visual condition, including:

(I) acquisition and use of unique assistive technology (e.g., computers, printers, scanners, screen access, note-taking devices, software, speech output devices, CCTV, etc.)

(II) acquisition and use of specialized equipment and materials (Braille writer, abacus, slate and stylus, paper, Braille/large print/cassette textbooks, tactile maps, charts, graphs, optical, and nonoptical aids, etc.)

(III) modification of the physical environment

(IV) implementation of appropriate instructional strategies

(V) incorporation of basic orientation and mobility skills

(vii) Demonstrates knowledge and applies skills relative to the management of student behavior and social interaction skills unique to students with visual impairments, including:

(I) influences of the disability (ies) and other factors impacting the child's behavior and social skills

(II) instruction in social interaction skills, adaptive behavior, and appropriate behaviors

(III) appropriate behavior management and ethical considerations using a variety of interventions and techniques

(viii) Demonstrates knowledge and skills in communication and collaborative partnerships, including:

(I) communication with families, professionals, ancillary personnel, student peers, and community members to improve the quality of education for students with visual impairments

(II) interrelationships of resource and related service providers

(III) educational activities regarding specific visual conditions through inservice, consultation, etc.

(IV) transition planning

(ix) Demonstrates knowledge and skills to promote successful transitions at all levels of the education process and in various environments, including:

(I) completion of secondary level program/postsecondary planning

(II) transitions across programs and service delivery systems

(x) Demonstrates knowledge and skills in providing an appropriate education for students in the least restrictive environment, including the full continuum of placement alternatives

(xi) Demonstrates management skills pertaining to the various service delivery models representing the full continuum of placement options for students with visual impairments, including:

(I) time management and scheduling

(II) record keeping

(III) prioritizing caseload

(IV) roles and responsibilities

(V) travel issues relevant to service delivery

(VI) site specific climate and culture

(xii) Demonstrates professional and ethical conduct and advocacy for the unique needs of all students with visual impairments regardless of the availability of services.

(C) Deaf/hard of hearing. The candidate for licensure and certification:

(i) Understands the philosophical, historical, and legal foundations of special education for students who are deaf or hard of hearing, including:

(I) trends and issues in special education

(II) special education policies and procedures

(III) laws and regulations regarding special education

(ii) Demonstrates knowledge of characteristics and development of students who are deaf or hard of hearing, including:

(I) communication features (visual, spatial, tactile, auditory) necessary to enhance cognitive, emotional, and social development

(II) etiologies (causes) of hearing loss

(III) effects of onset, age of identification, and provision of services

(iii) Demonstrates knowledge and skills in assessment, diagnosis, evaluation, and eligibility determination within the multidisciplinary team process for students who are deaf or hard of hearing, including

(I) use of the natural/native/preferred language or mode of communication of the student

(II) interpretation of results for use in educational programming

(iv) Understands and demonstrates knowledge of the individualized education program (IEP) process by:

(I) using assessment results, in partnership with team members, to develop the IEP

(II) monitoring IEP progress

(v) Demonstrates knowledge and skills to plan and implement appropriate and effective instruction for students who are deaf or hard of hearing based upon knowledge of subject matter, curriculum goals, and students' individual abilities and needs by use of:

(I) multimedia skills

(II) techniques for modifying and adapting curriculum and materials to meet physical, sensory, cognitive, cultural, and communication needs in various learning environments

(vi) Plans and manages supportive teaching and learning environments that maximize opportunities for visually oriented and/or auditory learning and facilitate participation of students who are deaf or hard of hearing using:

(I) knowledge of current devices and assistive technology, including their application and resources (e.g., captioning, computers, augmentative communication devices, etc.)

(II) classroom management techniques

(vii) Demonstrates knowledge and skills in managing student behavior and social interaction skills, including:

(I) appropriate behavioral management and ethical considerations using a variety of interventions and techniques

(II) influences of the disability(ies) and other factors impacting the child's behavior and social interaction skills

(viii) Understands how language develops naturally and that early comprehensible communication influences the development of the whole child.

(ix) Demonstrates proficiency in the languages and modes of communication that are used in the instruction of students who are deaf or hard of hearing.

(x) Understands the social and cultural aspects of the deaf perspective and deaf experience.

(xi) Demonstrates knowledge and skills in communication and forming collaborative partnerships with families, professionals, and community members to improve the quality of education for students who are deaf or hard of hearing.

(xii) Demonstrates knowledge and skills to promote successful transitions at all levels of the education process and in various environments, including:

(I) completion of secondary level program/postsecondary planning

(II) transitions across programs and service delivery systems

(xiii) Demonstrates knowledge and skills in providing an appropriate education for students in the least restrictive environment, including the full continuum of placement alternatives.

(xiv) Demonstrates professional and ethical conduct in matters related to the education of students who are deaf or hard of hearing.

(D) Mild-moderate disabilities. The candidate for licensure and certification will demonstrate his/her mastery of these standards through the master of the Council for Exceptional Children's (CEC) Core Knowledge and Skills and through the mastery of the CEC Knowledge and Skill Base for Teachers of Students in Individualized General Curriculums. The candidate:

(i) Understands the philosophical, evidence-based principals and theories, historical and legal foundations of special education, and how these influence professional practices. These would include:

(I) trends and issues in special education;

(II) special education policies and procedures;

(III) laws and regulations regarding special education;

(IV) issues of human diversity and its relevance to special education;

(V) human issues that influence the field of special education; and

(VI) relationships of special education to the organization and functions of schools, school systems, and agencies.

(ii) Understands the similarities and differences in human development, the characteristics of all learners, and how exceptional conditions interact with the domains of human development to respond to varying abilities and behaviors of individuals with disabilities while demonstrating respect for their students.

(iii) Understands the effects that a disability (including aspects of cognition, communication, physical, medical, and social/emotional) can have on learning and how primary language, culture and familial background can interact with the student's disabilities to impact academic, and social abilities, attitudes, values, interests and career options. The understanding of these learning differences and their possible interactions provide the foundation upon which a special educator individualizes instruction to provide meaningful and challenging learning for students with disabilities.

(iv) Possesses a repertoire of evidenced-based instructional strategies to individualize instruction for students with disabilities and emphasizes the development, maintenance, and generalization of knowledge and skills across environments, settings, and the life span. These evidenced-based instructional strategies should:

(I) promote positive learning results in the general curriculum in age-appropriate settings;

(II) promote multiple methods for teaching reading;

(III) modify learning environments;

(IV) enhance critical thinking, problem solving and performance skills;

(V) promote self-determination;

(VI) enhance integration and coordination of related services for educational benefit; and

(VII) promote transition.

(v) Demonstrates knowledge and skills in creating positive and safe learning environments for students with disabilities, and that also foster active engagement of students with disabilities. In addition, special educators foster environments that:

(I) value diversity;

(II) promote independence and productivity;

(III) assist general education colleagues in integrating students with disabilities;

(IV) use direct motivational and instructional interventions;

(V) utilize positive behavior supports and crisis management techniques;

(VI) guide and direct paraprofessionals and others; and

(VII) provide specialized school health practices and techniques for health and safety.

(vi) Understands typical and atypical language development and uses strategies to enhance language development and teach communication skills to students with disabilities. This is accomplished by using:

(I) effective language models;

(II) augmentative, alternative and assistive technologies;

(III) communication strategies and resources to facilitate understanding of subject matter for students with disabilities and those students with disabilities whose primary language is not English; and

(IV) matching communication methods to the student's language proficiency and cultural and linguistic differences.

(vii) Develops long- and short-range instructional plans anchored in both general and special education curricula emphasizing:

(I) effective modeling;

(II) efficient guided practice;

(III) modifications based on ongoing analysis of the individuals learning progress;

(IV) collaboration;

(V) individualized transition plans;

(VI) use of appropriate technologies; and

(VII) positive behavior supports.

(viii) Understands legal policies and ethical principals of multiple types of assessment information related to referral, eligibility, program planning, instruction and placement of students with disabilities including those from culturally and linguistically diverse backgrounds. Special educators use assessment information to identify supports and adaptations required for students with

disabilities to access general and special curricula and participate in school, system and statewide assessment programs. Special educators regularly monitor students' progress and use appropriate technologies to support assessments. Special educators must understand:

(I) measurement theory and practices for addressing validity, reliability, norms, bias, and interpretation of assessment results and

(II) appropriate use and limitations of various assessment.

(ix) Demonstrates knowledge and skills regarding legal, professional, and ethical practices including:

(I) sensitivity to the many aspects of diversity;

(II) engaging in professional growth as lifelong learners;

(III) keeping current with evidence-based effective practices; and

(IV) participating in professional activities that benefit individuals with disabilities and their families.

(x) Routinely and effectively collaborates with families, colleagues, related service providers, community agencies and other resources in positive and culturally responsive ways to assure that the needs of students with disabilities are addressed including facilitation of successful transitions of students with disabilities across settings and services.

(E) Severe-profound/multiple disabilities. The candidate for licensure and certification will demonstrate his/her mastery of these standards through the mastery of the Council for Exceptional Children's (CEC) Core Knowledge and Skills and through the mastery of the CEC Knowledge and Skill Base for Teachers of Students in Independence Curriculums. The candidate:

(i) Understands the philosophical, evidence-based principals and theories, historical and legal foundations of special education, and how these influence professional practices. These would include:

(I) trends and issues in special education;

(II) special education policies and procedures;

(III) laws and regulations regarding special education;

(IV) issues of human diversity and its relevance to special education;

(V) human issues that influence the field of special education; and

(VI) relationships of special education to the organization and functions of schools, school systems, and agencies.

(ii) Understands the similarities and differences in human development, the characteristics of all learners, and how exceptional conditions interact with the domains of human development to respond to varying abilities and behaviors of individuals with disabilities while demonstrating respect for their students.

(iii) Understands the effects that a disability (including aspects of cognition, communication, physical, medical, and social/emotional) can have on learning and how primary language, culture and familial background can interact with the student's disabilities to impact academic, and social abilities, attitudes, values, interests and career options. The understanding of these learning differences and their possible interactions provide the foundation upon which a special educator individualizes instruction to provide meaningful and challenging learning for students with disabilities.

(iv) Possesses a repertoire of evidenced-based instructional strategies to individualize instruction for students with disabilities and emphasizes the development, maintenance, and generalization of knowledge and skills across environments, settings, and the life span. These evidenced-based instructional strategies should:

(I) promote positive learning results in general and special curricula in age-appropriate settings, especially functional curricula;

(II) modify learning environments;

(III) utilize community-based instruction and vocational instruction;

(IV) enhance communication skills;

(V) enhance critical thinking, problem solving and performance skills;

(VI) promote self-determination;

(VII) enhance integration and coordination of related services for educational benefit; and

(VIII) promote transition.

(v) Demonstrates knowledge and skills in creating positive and safe learning environments for students with disabilities, and that also foster active engagement of students with disabilities. In addition, special educators foster environments that:

(I) value diversity;

(II) promote independence and productivity;

(III) assist general education colleagues in integrating students with disabilities;

(IV) use direct motivational and instructional interventions;

(V) utilize positive behavior supports and crisis management techniques;

(VI) guide and direct paraprofessionals and others; and

(VII) provide specialized school health practices and techniques for health and safety.

(vi) Understands typical and atypical language development and uses strategies to enhance language development and teach communication skills to students with disabilities. This is accomplished by using:

(I) effective language models;

(II) augmentative, alternative and assistive technologies;

(III) communication strategies and resources to facilitate understanding of subject matter for students with disabilities and those students with disabilities whose primary language is not English; and

(IV) matching communication methods to the student's language proficiency and cultural and linguistic differences.

(vii) Develops long- and short-range instructional plans anchored in both general and special education curricula emphasizing:

(I) effective modeling;

(II) efficient guided practice;

(III) modifications based on ongoing analysis of the individuals learning progress;

(IV) collaboration;

(V) individualized transition plans;

(VI) use of appropriate technologies; and

(VII) positive behavior supports.

(viii) Understands legal policies and ethical principals of multiple types of assessment information related to referral, eligibility, program planning, instruction and placement of students with disabilities including those from culturally and linguistically diverse backgrounds. Special educators use assessment information to identify supports and adaptations required for students with disabilities to access general and special curricula and participate in school, system and statewide assessment programs. Special educators regularly monitor students' progress and use appropriate technologies to support assessments. Special educators must understand:

(I) measurement theory and practices for addressing validity, reliability, norms, bias, and interpretation of assessment results and

(II) appropriate use and limitations of various assessments.

(ix) Demonstrates knowledge and skills regarding legal, professional, and ethical practices including:

(I) sensitivity to the many aspects of diversity;

(II) engaging in professional growth as lifelong learners;

(III) keeping current with evidence-based effective practices; and

(IV) participating in professional activities that benefit individuals with disabilities and their families.

(x) Routinely and effectively collaborates with families, colleagues, related service providers, community agencies and other resources in positive and culturally responsive ways to assure that the needs of students with disabilities are addressed including facilitation of successful transitions of students with disabilities across settings and services.

(32) **Speech/drama/debate (Secondary).** The candidate for licensure and certification:

(A) Maintains a current knowledge of concepts of the field of speech communication including: oral interpretation of literature, theater, the electronic media, public speaking, argumentation, and critical thinking skills.

(B) Applies comprehension, analysis, interpretation, synthesis, and evaluation of vocal, verbal and nonverbal messages.

(C) Applies appropriate learning strategies for critical thinking, research, organization, and presentation of messages appropriate to participation in a democratic society.

(D) Communicates effectively in interpersonal, small group, and public communication situations using appropriate language and nonverbal signals.

(E) Understands the influence of social and historical contexts, and culture on public address and literature of the theater.

(F) Understands the impact of cultural diversity upon the communication process.

(G) Establishes a communication climate which encourages reflection, creativity, and critical thinking.

(H) Uses differing assessment strategies to evaluate student competencies in a variety of speaking/listening situations.

(I) Uses technology (i.e., videotaping of presentations, computers to generate visual aids and as a research tool) to enhance instruction.

(J) Understands and uses teaching strategies appropriate for the analysis and presentation of a variety of forms (genres) of public address and literature of the theater, available in electronic media and from printed sources.

(K) Understands the importance of effective communication skills in the personal and professional arenas.

(L) Understands the role of co-curricular and extracurricular activities in the development of student interest as an extension of the classroom instruction.

(M) Understands, teaches, and implements Oklahoma's Core Curriculum.

(33) **Speech-language pathologist.**

(A) The candidate for licensure and certification:

(i) Understands the models, theories and philosophies that provide the basis for the practice of speech/language pathology, in the following knowledge areas:

(I) content areas in speech/language pathology (language, articulation, voice, fluency, augmentative communication)

(II) etiologies which may contribute to communication impairments

(III) a working understanding of other assessments (medical, psychological, audiological, etc.)

(IV) modality (spoken, written, sign)

(ii) Accommodates the individual learning styles and communication/educational needs of the student.

(iii) Demonstrates the ability to screen, evaluate, and diagnose students with suspected communication impairments using a variety of formal and informal procedures.

(iv) Plans and implements intervention strategies and the appropriate service delivery models for students with communication impairments, including:

(I) determines least restrictive environment

(II) provides ongoing assessment and monitors IEP progress

(III) develops individualized education program (IEP)

(v) Facilitates the development of the student's functional and literate communication skills (i.e., how communication occurs including written language) across environments, including:

(I) developing modifications/adaptations

(II) determining transition service needs

(vi) Recognizes and understands the relationship among behavior, social interaction and communication impairments, and is able to determine realistic expectations for the student's personal and social behavior in various settings.

(vii) Uses collaborative strategies in working with parents, school, and community to address the needs of students with communication impairments.

(viii) Promotes and maintains competence and integrity in the practice of speech/language pathology as follows:

(I) develops a plan for professional development

(II) identifies community agencies and resources

(ix) Implements practices that recognize the multicultural issues and the effect of cultural and linguistic diversity on students' communication skills and learning styles.

(x) Demonstrates knowledge of laws and regulations pertaining to students with communication impairments.

(B) Competency for Speech-language Pathologist certification may also be verified by the Certificate of Clinical Competence (C.C.C.) from the American Speech-Language Hearing Association (ASHA).

(34) **Agricultural education.** The candidate for licensure and certification shall possess the competencies specified in (A) through (F).

(A) **Agricultural business/marketing.** The candidate for licensure and certification understands the fundamental principles of agricultural business/marketing and management including principles of basic recordkeeping and methods for acquiring and managing agricultural finances.

(B) **Animal science.** The candidate for licensure and certification:

(i) Selects and handles livestock, recognizes factors related to the safe handling of animals and animal products which become food for human consumption, and understands the importance of alternative agricultural enterprises.

(ii) Understands concepts and principles of animal reproduction and the importance of livestock health and nutrition.

(C) **Plant and soil science.** The candidate for licensure and certification:

(i) Understands concepts, principles, and laboratory skills related to plant and soil science including the importance of traditional crops and alternative enterprises.

(ii) Knows factors related to the safe handling of plants and plant products which become food for human consumption and identifies causes and characteristics of common plant pests and diseases.

(D) **Agricultural mechanics.** The candidate for licensure and certification practices:

(i) shop safety, including the operation and knowledge of hand/power tools,

(ii) basic principles/concepts of power and machinery, metals and metal processes, and

(iii) basic principles of building construction.

(E) **Natural resources.** The candidate for licensure and certification:

(i) Evaluates the relationship between agriculture and the management of water, land, and air quality, and

(ii) Understands concepts and principles of plant and animal environmental factors including the handling of chemicals.

(F) **Communications/leadership.** The candidate for licensure and certification:

(i) Acknowledges the foundations of agricultural education including its purpose, functions, and the background of Future Farmers of America (FFA).

(ii) Demonstrates an understanding of basic parliamentary procedure, effective oral and written communication skills, and promotes teamwork, motivation, and leadership principles.

(35) **Marketing education.** The candidate for licensure and certification shall possess the competencies specified in (A) through (N).

(A) **Orientation.** The candidate for licensure and certification applies principles of job search and preparation skills relating to resume and portfolio development, proper completion of application forms, interview preparation, career ladder analysis, and computer technology skills relating to word-processing and computerized presentations.

(B) **Marketing.** The candidate for licensure and certification:

(i) Applies principles and concepts related to marketing.

(ii) Interprets the importance of the marketing concept and functions, how marketing affects society, factors to consider in selecting a channel of distribution, and the concept of target marketing.

(C) **Mathematical skills.** The candidate for licensure and certification:

(i) Applies basic mathematical operations used in the marketing profession as it pertains to balancing a cash drawer and the automatic and manual methods of making change.

(ii) Identifies the uses of basic algebra in marketing.

(D) **Human relations.** The candidate for licensure and certification:

(i) Applies principles of communications, decision-making, and crisis management.

(ii) Identifies characteristics of professionalism on the job and the importance of social skills.

(E) **Sales.** The candidate for licensure and certification:

(i) Applies principles relating to sales, product information, customer buying decisions, motives for buying, and sales approaches.

(ii) Demonstrates methods of handling customer/client complaints and objections.

(iii) Explains the concept and use of sales quotas.

(F) **Security precautions.** The candidate for licensure and certification:

(i) Identifies and explains prevention measures for the security problems of shoplifting, internal theft, burglary, robbery, and fraud.

(ii) Identifies common types of fraud.

(iii) Recognizes steps necessary to ensure security in shipping and receiving areas.

(iv) Identifies precautions for safety on the job.

(G) **Economics.** The candidate for licensure and certification:

(i) Applies principles related to the classification of goods and services and the types of economic resources.

(ii) Compares the types of economic systems and their relationship to the economy.

(iii) Identifies the factors which affect economics including economic utility (form, place, time, possession), competition, supply and demand, and the role of government in business.

(iv) Understands the characteristics and importance of a private enterprise system and international trade.

(v) Identifies the measure and importance of the gross domestic product (GDP) to marketing.

(H) **Promotion.** The candidate for licensure and certification:

(i) Applies principles related to the use of promotional activities, including the use of media, design and display arrangements, and the print ad.

(ii) Explains the role of the promotional plan.

(I) **Merchandising.** The candidate for licensure and certification applies principles related to shipping and receiving, inventory control systems, calculation of inventory shrinkage, and industrial purchasing.

(J) **Business ownership/entrepreneurship.** The candidate for licensure and certification:

(i) Identifies the common types of business ownership in a free enterprise system and the advantages/disadvantages of each.

(ii) Discusses the importance of marketing strategies to businesses as they apply the principles of the product mix, product/service planning, marketing decisions for a proposed business, structuring a business, and using four "Ps" of marketing - product, pricing, place, and promotional strategies.

(K) **Applied management.** The candidate for licensure and certification:

(i) Applies principles of selecting store personnel, recruiting applicants for job openings, interviewing job candidates, and reducing labor turnover.

(ii) Recognizes the importance of new-employee orientation.

(iii) Understands knowledge of employee motivational theories.

(L) **Credit.** The candidate for licensure and certification:

(i) Applies principles of extending credit to business and customers and the three Cs of credit: character, capacity to pay, and capital.

(ii) Identifies the reasons for extending credit.

(M) **Business and industry.** The candidate for licensure and certification:

(i) Develops relationships with business and industry through advisory committees, surveys, work-site learning opportunities, curriculum, and program visits.

(ii) Communicates with business and industry regarding student competencies/credentials and job performance.

(N) **Student organizations and activities.** The candidate for licensure and certification:

(i) Understands the role of student organizations in developing student professionalism and assists student organizations by coaching, chaperoning, and supervising activities.

(ii) Encourages student participation through instruction and recognition of student achievements.

(36) **Technology ~~education~~engineering.** The candidate for licensure and certification shall possess the competencies specified in (A) through (J):

(A) **Fundamentals of technology.** The candidate for licensure and certification:

(i) Understands the ~~fundamentals of technology~~historical and social content including important events, developments, components, and current and future trends of technology.

(ii) Defines the terms, systems, characteristics, interrelationships, and economics of ~~technology, and their utilization in modern business and industry.~~the connection between other disciplines such as math, science, and engineering.

(iii) Identifies general laboratory and personal safety practices.

(iv) Understands process and procedures related to the design process.

(B) **Problem-solving techniques.** The candidate for licensure and certification:

~~(i) Identifies problem-solving techniques.~~

(~~ii~~i) Understands and applies problem-solving techniques.

(ii) Applies knowledge of engineering to solve technology related problems.

(C) **Career opportunities.** The candidate for licensure and certification:

(i) Explores career opportunities based on career clusters and identifies related terms and definitions.

(ii) Identifies activities that develop employability skills.

(iii) Recognizes educational requirements and ~~paths for occupational attainment.~~pathways for occupational or postsecondary attainment.

(D) **~~Communication systems.~~Arts/AV communication and information technology systems.** The candidate for licensure and certification:

(i) Understands the principles, processes, ~~and functions of communication.~~tools, equipment, materials, functions, and characteristics of Arts/AV and Communication Technologies.

~~(ii) Identifies types of communication technologies.~~

(ii) Understands Information Techology processes and procedures related to graphic communications.

(E) **~~Construction~~Architecture and Construction systems.** The candidate for licensure and certification:

(i) Understands and applies the principles ~~of construction technology.~~and characteristics of architecture and construction.

~~(ii) Identifies construction technologies, their effects on society, basic principles of project planning, and steps in the construction process.~~

(ii) Identifies architecture and construction processes, procedures, basic principles of project planning, legal and regulatory issues, equipment and materials, and steps in the construction process.

(F) **Manufacturing systems.** The candidate for licensure and certification:

(i) Understands manufacturing principles ~~of manufacturing and their application.~~and characteristics and their application.

(ii) Identifies materials, equipment, processes, and strategies utilized in manufacturing technologies.

(iii) Analyzes the role, function, and responsibilities of manufacturing in a contemporary society.

(G) **~~Energy, power and transportation systems.~~Transportation, distribution, and logistics (TDL).** The candidate for licensure and certification:

(i) Understands the principles~~ and applications of energy, power, and transportation.~~, procedures, and applications of transportation, distribution, and logistics.

~~(ii) Identifies forms of energy, their classification, and their characteristics.~~

~~(iii) Analyzes power systems and transportation technologies, as well as their characteristics.~~

(ii) Identifies the selection of tools, equipment, and materials in the transportation, distribution, and logistics industry.

(~~iv~~iii) Analyzes environmental and economic effects on society.

(H) **Technology ~~education~~engineering delivery systems.** The candidate for licensure and certification:

(i) Understands basic technology engineering principles, terminology, system design, and issues related to ~~technology education delivery systems and telecommunication.~~technology engineering.

(ii) Identifies terms, features, relationships, and procedures ~~associated with~~related to the selection, operation, and maintenance of computer systems and technology ~~education~~engineering software.

(iii) Analyzes factors ~~affecting~~effecting the selection of computer hardware and software.

(I) **Business and industry.** The candidate for licensure and certification develops relationships with business and industry through advisory committees, curriculum, and work-site learning opportunities.

(J) **Student organizations and activities.** The candidate for licensure and certification:

(i) Understands the role of student organizations in encouraging student participation and implementing activities that develop leadership traits.

(ii) Integrates student activities in instruction and recognizes student achievements.

(37) **Vocational business.** The candidate for licensure and certification shall possess competencies specified in (A) through (D).

(A) **Business foundations.** The candidate for licensure and certification:

(i) Understands important events, developments and trends in the history of business.

(ii) Understands business organizational structures, organizational design and their implications.

(iii) Understands the basic principles of business law and the types and characteristics of legal instruments.

(iv) Analyzes legal issues related to business.

(v) Understands business communication.

(B) **Business management.** The candidate for licensure and certification:

(i) Understands principles of business management and their applications in the decision-making process

(ii) Applies procedures for managing human resources.

(iii) Analyzes issues related to economic and social responsibilities in business.

(iv) Analyzes factors affecting business marketing decisions.

(C) **Technology systems.** The candidate for licensure and certification:

(i) Understands basic principles and terminology related to computer technology.

(ii) Understands principles of computer system design.

(iii) Applies principles of computer technology to solve problems involving information gathering and analysis.

(iv) Applies principles of computer technology to solve problems related to project and business management.

(v) Understands information processing systems.

(vi) Analyzes data storage, retrieval and transmission systems.

(vii) Understands principles of telecommunications and applications of telecommunications in business.

(viii) Analyzes ethical and security issues involving technology systems.

(D) **Business finance and economics.** The candidate for licensure and certification:

(i) Understands basic principles and applications of accounting.

(ii) Applies procedures for processing accounting data.

(iii) Understands advanced accounting concepts and procedures.

(iv) Understands basic principles and applications of macroeconomics.

(v) Analyzes business situations in terms of microeconomic theory.

(vi) Applies basic principles of consumer economics and finance.

(38) **Vocational family and consumer sciences.** The candidate for licensure and certification shall possess the competencies specified in (A) through (I).

(A) **Child development.** The candidate for licensure and certification:

(i) Applies child development concepts and guidance techniques in the care of infants, toddlers, preschool and school-age children, as well as children in crisis or with special needs.

(ii) Analyzes issues related to children's well-being, parenting, pregnancy, prenatal care, child birth, child care services, and community resources.

(B) **Foods and nutrition.** The candidate for licensure and certification:

(i) Analyzes the relationship between food, nutrients, and the body through the application of food science principles, and healthy food choices.

(ii) Understands proper food storage/handling techniques, recipe use, food product information, serving/dining etiquette, and consumer skills.

(C) **Consumer economics and management.** The candidate for licensure and certification:

(i) Applies principles related to money management, personal financial management, time management, and economics.

(ii) Analyzes advertising influences, factors related to housing selection and maintenance, factors related to motor vehicle selection and maintenance, wills, funerals, and consumer credit.

(iii) Applies consumer protection practices and skills.

(D) **Housing and interior design.** The candidate for licensure and certification:

(i) Plans living space for human needs through the evaluation of housing and financial alternatives.

(ii) Applies elements and principles of interior design including exterior styles, interior spaces, interior treatments, furniture, accessories, and appliances.

(E) **Interpersonal relationships.** The candidate for licensure and certification:

(i) Applies principles of communications, decision making, and crisis management.

(ii) Discusses factors and issues related to parenting, family life, and aging.

(iii) Identifies the importance of self-respect and of practicing socially accepted behavior.

(F) **Clothing and textiles.** The candidate for licensure and certification:

(i) Applies wardrobe planning and grooming skills.

(ii) Applies clothing selection skills, methods of stretching the clothing dollar, care and maintenance practices, construction techniques, and knowledge of types of textiles.

(G) **Careers.** The candidate for licensure and certification:

(i) Investigates careers as they relate to personal and career goals.

(ii) Understands the job application process, factors related to work etiquette, the use of technology in the workplace, and economic principles.

(H) **Business and industry.** The candidate for licensure and certification:

(i) Develops partnerships with business and industry through advisory committees, surveys, work-site learning opportunities, curriculum, and program visits.

(ii) Communicates with business and industry regarding student competencies/credentials and job performance.

(I) **Student organizations and activities.** The candidate for licensure and certification:

(i) Understands the role of student organizations in the recognition of student achievements through curricular activities.

(ii) Encourages student participation and the development of leadership traits.

(39) **Occupational agriculture, occupational family and consumer sciences, trade and industrial education, and vocational health occupations.** Competency for occupational agriculture, occupational family and consumer sciences, trade and industrial education, and vocational health occupations will be verified by passing a state or national licensure examination developed specifically to the occupation and/or occupational testing approved by the Oklahoma Department of Vocational and Technical Education. Non-degreed vocational teachers certified under rules promulgated by the State Board of Education are exempt from the provisions of House Bill 1549, except for those provisions concerning professional development programs.

(40) **Dance education.** The candidate for licensure and certification:

(A) Has a sound philosophical understanding and knowledge of dance education and creative movement and can support, justify and implement the dance education.

(B) Has a thorough knowledge of a sequential dance/creative movement curriculum that is developmentally appropriate for each grade level and inclusive of various student learning styles and those with special needs.

(C) Understands the history of dance and its role in culture and the arts worldwide.

(D) Has a working knowledge of dance integration and values the art-related competencies in Oklahoma's core curriculum.

(E) Recognizes and respects diversity and establishes environments where individuals dance content and learning are held in high regard.

(F) Understands the process of critical thinking and implements problem solving activities, analysis, reflection, decision making and creative exploration in dance.

(G) Understands the elements of dance and technical skills in performing dance including:

(i) time (i.e., fast slow, even, uneven, accent, meters)

(ii) space (i.e., levels , direction, pathways)

(iii) force (i.e., energy, weight, flow)

(iv) locomotor movements (i.e., walk, run, skip, hop, jump, slide, gallop, leap)

(v) nonlocomotor movements (i.e., bend, stretch, twist, swing)

(vi) rhythmic activities and musicality

(vii) proper skeletal alignment

(viii) efficiency and mastery of technical skills in a variety of dance forms.

(H) Understands the principals of choreography (i.e., dance improvisation, composition, and choreography).

(I) Understands the components of healthy living and fitness and the benefits of daily participation in dance activities.

(i) fitness components

(I) flexibility

(II) muscular strength

(III) agility

(IV) motor skills development and coordination

(V) body awareness, control, and balance

(VI) development and mastery of dance skills

(VII) weight control

(ii) wellness components

(I) release of stress and tension through positive dance activity

(II) positive self esteem and self-expression

(III) lifelong well being

(IV) weight control

(J) Has a working knowledge of dance choreography and teaching strategies to help students create, study, interpret and evaluate works of art.

(K) Has knowledge of dance resources including community resources, materials, equipment, and proper facilities, and can adapt a variety of resources and materials that supports students as they learn through and about dance.

(L) Promotes the understanding of dance as an artistic, kinesthetic, educational, social, cultural and theatrical experience.

(M) Provides a safe environment and creates a setting for productive learning.

(N) Collaborates with colleagues, artists and agencies in the community to promote arts education opportunities.

(O) Recognizes the important role of technology in dance education.

(P) Uses a variety of assessment and evaluation methods and can evaluate student learning.

(41) **English as a second language (ESL) PK-12.** The candidate for licensure and certification:

(A) **Language.** The candidate for licensure and certification:

(i) Demonstrates knowledge, understanding, and application of the fundamentals of linguistics as related to the development of listening, speaking, reading, and writing for social and academic purposes.

(ii) Understands and applies knowledge of current theories and practices that facilitate second language acquisition and literacy development in the classroom.

(iii) Understands the role of the primary language in acquiring English as a new language.

(iv) Understands and applies knowledge of how sociocultural variables effect individual learners in facilitating the process of learning English.

(B) **Culture.** The candidate for licensure and certification:

(i) Knows, understands, and uses the major concepts, principles, theories, and research related to the nature and role of culture in language development and academic achievement that support individual student's learning.

(ii) Understands and applies knowledge about home/school communication to enhance ESL teaching and build partnerships with students' families.

(iii) Knows, understands, and uses knowledge of how cultural groups and ESL students' cultural identities affect language learning and school achievement.

(iv) Understands and applies knowledge about world events that have an impact on ESL students' learning.

(v) Knows and uses teaching strategies that are developmentally appropriate and inclusive of various learning styles and is sensitive to the needs of diverse cultural groups.

(C) **Planning, implementation, and managing instruction.** The candidate for licensure and certification:

(i) Knows, understands, and applies concepts, research, and best practices to plan standards-based instruction based on language development and the Oklahoma core curriculum that provides for students of varying educational backgrounds in a supportive and accepting environment.

(ii) Knows, manages, and implements instruction around standards-based subject matter and language learning objectives that incorporates a variety of activities and learning opportunities that integrate listening, speaking, reading, writing, and comprehension for a variety of academic and social purposes.

(iii) Knows and is able to use a variety of resources and instructional strategies to teach ESL students the English language and content areas.

(iv) Understands and applies the following competencies in reading instruction as appropriate to the abilities of the student.

(I) Knows the stages of language development and the structure of the English language and alphabetic writing system including phonology, morphology, and orthography and their relationships to spelling and meaning.

(II) Understands that primary language (oral) directly impacts the secondary languages (reading, writing, spelling). Knows and applies knowledge of implicit and explicit instruction in developing oral language. Knows the relationship of oral language to literacy.

(III) Knows the developmental process of reading in order to assess, interpret, describe, develop appropriate instruction, monitor, reteach and reassess student's reading performance for concepts about print, phonological and phonemic awareness, phonics, spelling, word recognition, vocabulary, comprehension, fluency, and writing.

(IV) Identifies and applies all developmental levels of phonemic awareness to provide appropriate instruction in understanding words are made up of phonemes and that phonemes can be rearranged and manipulated to make different words that compose oral speech.

(V) Knows and provides appropriate systematic explicit and implicit phonological instruction for the application of spelling-sound correspondences for word analysis and for structural analysis for word recognition and word meaning development.

(VI) Knows and applies the relationships between spelling patterns and sounds of speech; knows how to support the student at each stage of spelling development; knows how to focus direct and indirect instruction to guide the student toward spelling proficiency.

(VII) Knows and applies knowledge of appropriate explicit and implicit instruction for vocabulary development (e.g., prefixes, suffixes, roots, singular, and plural).

(VIII) Knows and applies strategies that promote comprehension and strategies to support

children's understanding for the various elements of the different genres of text.

(IX) Knows and applies strategies and instructional approaches to support response to text and promote comprehension for literal, inferential, and critical/evaluative level (e.g., guided reading, literature and research circles).

(X) Knows and applies knowledge of instructional techniques to assist students with self-monitoring and self-corrections~~,~~ (i.e., semantics, syntax, and graphophonics).

(XI) Knows and applies the instructional strategies which contribute to the development of fluent reading.

(XII) Knows how to promote children's interest and engagement in reading and writing.

(D) **Assessment.** The candidate for licensure and certification:

(i) Understands various issues of standardized assessments as they affect ESL students' learning and academic performance.

(ii) Understands different types of assessments and their purposes.

(iii) Understands and is able to use a variety of language proficiency assessment instruments.

(iv) Interprets and integrates assessment information into instructional plans.

(v) Understands the importance of different assessment strategies and uses them in the evaluation and modification of teaching and learning.

(E) **Professionalism.** The candidate for licensure and certification:

(i) Demonstrates knowledge of history, research, and current practices in the field of ESL and applies this knowledge to improve teaching and student achievement.

(ii) Pursues personal professional growth opportunities and serves as a professional resource to colleagues.

(iii) Serves as a resource liaison and advocate for ESL students and builds partnerships with students' families.

(iv) Demonstrate English fluency in listening, speaking, reading, and writing the English language.

(42) **Computer Science.** The candidate for licensure and certification shall possess the competencies specified in (A) through (E).

(A) **Programming and algorithm design.** The candidate for licensure and certification will demonstrate programming proficiency in a modern high-level programming language. The candidate will:

(i) Demonstrate knowledge of and skill regarding the syntax and semantics of a high-level programming language, its control structures, and its basic data representations.

(ii) Demonstrate knowledge of and skill regarding common data abstraction mechanisms (e.g., data types or classes such as stacks, trees, lists, etc.).

(iii) Demonstrate knowledge of and skill regarding program correctness issues and practices (e.g., testing program results, test data design).

(B) **Multiple paradigms.** The candidate for licensure and certification will demonstrate an understanding of and flexibility with differing approaches/paradigms in programming (e.g., imperative, functional, object-oriented). The candidate will design, implement, and test programs in languages from two different programming paradigms in a manner appropriate to each paradigm.

(C) **Computer systems - components, organization, and operation.** The candidate for licensure and certification will demonstrate in-depth knowledge of how computer systems work individually and collectively. The candidate will:

(i) Use a variety of computing environments (e.g., various operating systems)

(ii) Describe the operation of a computer system-CPU and instruction cycle, peripherals, operating system, network components, and applications indicating their purposes and interactions among them.

(D) **Data representation and information organization.** The candidate for licensure and certification will demonstrate an understanding of data and information representation and organization at a variety of levels--machine level representation (for program correctness), data structures (for program implementation), problem representation (for solution design), files and databases (for general applications), and interactions among systems and people (for overall system design and effectiveness). The candidate will:

(i) Describe how data is represented at the machine level (e.g., character, boolean, integer, floating point).

(ii) Identify and provide usage examples of the various data structures and files provided by a programming language (e.g., objects, various collections, files).

(iii) Describe the elements (people, hardware, software, etc.) and their interactions within information systems (database systems, the Web, etc.).

(E) **Social aspects of computing.** The candidate for licensure and certification will conduct independent learning on specific, unfamiliar topics in general areas central to computer science and provide their candidates with opportunities to do the same. The candidate will:

(i) Demonstrate awareness of social issues related to the use of computers in society and principles for making informed decisions regarding them (e.g., security, privacy, intellectual property, equitable access to technology resources, gender

issues, cultural diversity, differences in learner needs, limits of computing, rapid change).

(ii) Analyze various social issues involving computing, producing defensible conclusions.

(iii) Demonstrate an understanding of significant historical events relative to computing.

SUBCHAPTER 11. PROFESSIONAL STANDARDS: ACCREDITATION STANDARDS FOR APPROVED TEACHER EDUCATION PROGRAMS

210:20-11-3. General education and professional education

(a) General Education is based on those studies known as the liberal arts which embrace the broad areas of the humanities, mathematics, the biological and physical sciences, the social and behavioral sciences, and oral and written communication skills. College credit used to satisfy the requirements in General Education, in an amount not to exceed twelve (12) semester hours, may also be counted in meeting requirements in the field of Specialization. College credit used to satisfy the requirements in Professional Education shall not be counted toward meeting requirements in General Education. The General Education component of each approved certificate program must meet or exceed the following standards:

(1) Standard I: The General Education Program shall:

(A) Stimulate scholarship that will give understanding and help prepare people for change;

(B) Foster individual fulfillment and nurture free, rational, and responsible adults;

(C) Cultivate appreciation for the values associated with a free society;

(D) Contribute to the development of leaders who are intellectually competent, imaginative, and vigorous;

(E) Contribute to professional knowledge and its application; and

(F) Encourage discernment of the values inherent in world cultures.

(2) Standard II: General Education is a developmental experience emphasizing the first two (2) years of higher education and extending throughout the baccalaureate program.

(3) Standard III: Each institution approved for the education of teachers shall be responsible for building a sequential program of general studies. A minimum of fifty (50) semester hours in General Education is required, distributed so that:

(A) Upon successful completion of the General Education component, the student shall have acquired competencies in each of the following areas:

(i) Communication Skills: conversational speaking, composition, listening, and reading

(ii) Mathematics: computation, applications, thought processes, vocabulary, and concepts;

(iii) United States History and Government: The growth and development of the United States as a nation, its place in world affairs, and an analysis of the United States Constitutional Government;

(iv) Science: physical and biological science

(v) Behavioral Sciences: The study of psychology, and/or sociology, and/or anthropology; and

(vi) Arts and Humanities: The study of significant ideas of western civilization as manifested in art, literature, music and philosophy (course work shall be completed in a minimum of two (2) of these areas).

(B) Any electives needed to fulfill the fifty (50) hour minimum requirement may be selected from category A or the following:

(i) Contemporary World Culture: social, geographic, political and economic conditions and their impact on current problems in the world and nations, foreign language, American ethnic studies, and world literature with emphasis on, but not limited to, the writings of English and American authors;

(ii) Practical Arts: skills in areas such as typing, business, accounting, home economics, industrial arts/technology ~~education~~engineering, agriculture, drafting, computer science, and library science; and

(iii) Health and Physical Education: the principles of health and physical education as they apply to the individual and the community.

(b) Professional Education shall include classroom and field experiences incorporating a minimum of thirty (30) semester hours. These experiences shall include course work fulfilling the criteria specified below. College credit used to satisfy the requirements in Professional Education shall not be counted in meeting requirements in the field of Specialization except where specifically designated in the Standards. College credit used to satisfy the requirements in Professional Education shall not be counted toward meeting requirements in General Education.

The fulfillment of the Professional Education sequence shall include evidence that the candidate has successfully completed:

(1) Appropriate laboratory and field experiences designed to provide a preservice teacher an opportunity to synthesize, apply and extend knowledge and problem solving abilities acquired in educational foundations, theory, methods courses, and principal subject areas;

(2) A minimum of forty-five (45) clock hours of supervised developmental and sequential prestudent teaching experiences in the field;

(3) A student teaching experience equivalent to one (1) semester of at least twelve (12) weeks in the school environment; and

(4) Course work in each of the following areas: Foundations of Education, Human Growth and Development,

Learning, Evaluation, Exceptional Child, Media, Methods, and Student Teaching.

(5) Standard I: The Professional Education sequence shall include course work in the processes of human growth, development, and learning and the practical application of this knowledge to the instructional process. The student shall demonstrate a knowledge of:

(A) Individual differences among students such as interests, values, cultural and socioeconomic background;

(B) Strategies to utilize data in grouping students for learning activities;

(C) The development of instructional goals and objectives appropriate to student needs and learning modes;

(D) Sequencing learning activities and experiences both logically and psychologically;

(E) Behavior patterns of students;

(F) Classroom conditions which are varied and appropriate; and

(G) Student self-awareness and positive self-concepts.

(6) Standard II: The Professional Education sequence shall include course work in the foundations underlying the development and organization of education in the United States. The student shall demonstrate a knowledge of:

(A) The historical and philosophical development of education in the United States;

(B) The organization of public schools;

(C) Cultural pluralism as it relates to the public schools;

(D) The development of education as a profession;

(E) Legal and ethical considerations of school personnel including the rights and responsibilities of teachers, students, administrators, and staff;

(F) The characteristics of effective teachers;

(G) Democratic principles, free public education, and equal educational opportunity;

(H) Objectives and purposes of education relating to pupils, parents, and other citizens; and

(I) School programs and the participatory role of the teacher in activities which contribute to student and faculty development.

(7) Standard III: The Professional Education sequence shall include course work in measurement, methods, materials, and media appropriate to teaching. Emphasis shall be in the student's field(s) of Specialization. The student shall demonstrate a knowledge of:

(A) Administration and interpretation of assessment techniques (standardized tests, sociometrics, etc);

(B) Design and use of teacher-made tests (diagnostic and achievement, etc);

(C) Appropriate organization of instructional resources and materials for effective teaching;

(D) A variety of appropriate instruction strategies (programmed instruction, games, simulations, etc.);

(E) The appropriate use of a variety of communication patterns within the classroom;

(F) Individualization of instruction when appropriate;

(G) Interaction patterns and the ability to modify plans on the basis of feedback; and

(H) Incorporating reading techniques in content subjects.

(8) Standard IV: the Professional Education sequence shall include course work in the purposes, administrative organization, and operation of the total educational program of the school. The student shall demonstrate a knowledge of:

(A) Cultural pluralism concepts;

(B) Effective interaction and communication with parents;

(C) The organization of public schools;

(D) The major contemporary problems in public education;

(E) The professional organizations in education; and

(F) The requirements for accreditation, licensure, and certification.

(9) Standard V: The Professional Education sequence shall include opportunities to demonstrate abilities to teach effectively and work ethically with pupils, teachers, administrators, and parents. Documentation shall be provided (rating scales, systematic observation, video tape, etc.) to evaluate the student teacher's ability to:

(A) Differentiate among the appropriate roles and responsibilities of pupils, teachers, administrators, paraprofessionals, and parents;

(B) Organize and implement a variety of activities to facilitate learning;

(C) Exhibit professional scholarship and behavior;

(D) Interact and communicate effectively with parents;

(E) Conceptualize and predict accurately the interaction of influencing variables in teaching and learning;

(F) Identify and become sensitive to individual differences among students;

(G) Plan, implement, and evaluate appropriate educational goals and related experiences for students; and

(H) Work effectively as a member of an educational team.

[OAR Docket #10-774; filed 5-6-10]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 20. STAFF

[OAR Docket #10-770]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 9. Professional Standards: Teacher Education and Certification
Part 9. Teacher Certification
210:20-9-95. Effective date of teaching certificates and licenses [AMENDED]
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70 O. S. § 3-104, State Board of Education
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Part 9. Teacher Certification
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January 14, 2010
Register Publication:
27 Ok Reg 596
Docket Number:
10-127
INCORPORATION BY REFERENCE:
N/A
ANALYSIS:
In accordance with 68 O. S. § 6-238 rule amendments will clarify effective renewal dates of an educator's credential if they are not in compliance with Oklahoma tax laws.
CONTACT PERSON:
Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2010:

SUBCHAPTER 9. PROFESSIONAL STANDARDS: TEACHER EDUCATION AND CERTIFICATION

PART 9. TEACHER CERTIFICATION

210:20-9-95. Effective date of teaching certificates and licenses

(a) **New licenses/certificates.** A license/certificate issued to an applicant who completes all requirements and applies for the license/certificate between May 1 and September 1 will be dated and become effective July 1. A license/certificate issued to an applicant who completes all requirements and applies for the license/certificate between September 1 and May 1 will be dated and become effective the first day of the month in which the application and all supporting documents are received by the State Board of Education.

(b) **Renewal of standard certificates and licenses.** Renewed standard certificates and licenses will become effective July 1 following receipt of the application provided the application is made prior to the expiration of the certificate/license. If the application for renewal is made after the certificate/license has expired, the renewed certificate/license will be dated the first day of the month in which the application and all supporting documents are received. In the event an educator's certificate/license cannot be renewed due to failure to comply with Oklahoma's tax laws, the renewed certificate/license will be dated the date the State Department of Education receives notice from the Tax Commission that the educator has come into compliance.

[OAR Docket #10-770; filed 5-6-10]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 40. GRANTS AND PROGRAMS-IN-AID

[OAR Docket #10-771]

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RULES:
Subchapter 52. Advanced Placement Incentive Program
210:40-52-5. Equipment and materials grants and vertical teaming grants [AMENDED]
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Subchapter 52. Advanced Placement Incentive Program
210:40-52-5. Equipment and materials grants and vertical teaming grants [AMENDED]

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27 Ok Reg 107
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N/A
ANALYSIS:
The rule amendments will include programs that include middle schools across the state. Language will include programs that train teachers where currently the grant language only encompasses materials and equipment. Districts that do not spend their grant money will have funds withheld from AP incentive funds rather than state aid.
CONTACT PERSON:
Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2010.

SUBCHAPTER 52. ADVANCED PLACEMENT INCENTIVE PROGRAM

210:40-52-5. Equipment and materials grants and vertical teaming grants

(a) At such point in the legislative session that state funds are appropriated for this competitive grant program to be awarded by the State Board of Education, and administered by the State Department of Education, a notification letter will be sent to each district superintendent announcing the availability of application forms.

(1) The notification will clearly state those grant programs for which applications are being solicited and state the name and telephone number of the contact person at the Department who administers the program.

(2) The original grant application and three (3) copies will be submitted to the grant administrator. A specific deadline date will be clearly stated in the application solicitation letter. This date may vary from year to year depending on the point in the legislative session that grant funds are appropriated.

(3) The signature of the Chief Executive Officer of the local educational agency must appear on the application.

(4) The Oklahoma Advanced Placement Incentives Program grants are site based. A school site may apply for a one-time equipment and materials grant of up to $5000 for each Advanced Placement or International Baccalaureate course. (Two sections of a course such as Advanced Placement Calculus are considered to be one course.)

(5) Additional grants may be awarded to school sites demonstrating successful implementation of the Advanced Placement or International Baccalaureate course for which the original equipment and materials grant was awarded. Successful implementation may be demonstrated by, but is not limited to:

(A) The class having been reported on the Application for Accreditation Coded Class Schedule.

(B) A student having completed the relevant Advanced Placement or International Baccalaureate examination.

(C) A student having scored three or better for Advanced Placement or four or better on International Baccalaureate on the relevant examination.

(D) Evidence of activities to prepare growing numbers of students for the challenges offered by the Advanced Placement or International Baccalaureate classes.

(6) Vertical team grants for the purpose of enabling school districts to prepare growing numbers of students for the challenges offered by the Advanced Placement or International Baccalaureate classes. Vertical team grants are content area and team-based. A school district may apply for a vertical team grant for a content area team from a high school and its feeder middle level school(s). The vertical team shall include at least one representative from each grade level in the content area for grades seven (7) through twelve (12).

(7) Grants for the purpose of implementing a program that supports training for the development or continuation of Advanced Placement (AP) or Pre-AP classes at a public middle or high school.

(b) The evaluation of the grant applications will take place following the submission deadline. Grant applications shall be read, evaluated, and scored by a committee of outside evaluators.

(1) Each evaluation committee member shall possess expertise relative to the content area of the grant.

(2) Selection committee members will not evaluate an application from his or her own site.

(3) Each application for an equipment and materials grant will be scored in the following areas:

(A) Rationale demonstrating understanding of program and need for funds

(B) Teacher quality relevant to preparation for teaching a challenging course and willingness to participate in professional development opportunities relative to Advanced Placement or International Baccalaureate curriculum

(C) Budget meets intent of the grant

(4) Each application for a vertical team grant will be scored in the following areas:

(A) Abstract briefly summarizing the grant proposal.

(B) Significance of the project answering the question, "How will the proposed vertical team address the program purpose?"

(C) Project design describing the steps to be taken to organize the Vertical Team as well as the steps to be taken to develop and sustain the Vertical Team.

(D) Vertical team make-up describing the staff positions to be included on the Vertical Team and describing the training of these persons.

(E) Program quality describing the degree to which the Advanced Placement or International Baccalaureate program has been implemented as defined in the grant application.

(F) Budget consistent with intent of the grant. Allowable expenditures include but are not limited to:

(i) Release time for vertical team members

(ii) Vertical team resources

(G) Expenditures which are not allowed include but are not limited to:

(i) Facilities

(ii) Training which is otherwise available through the Oklahoma Advanced Placement Incentives Program

(iii) Expenditures related to Internet access

(H) Program evaluation describing how the proposed vertical team will be evaluated in relation to the program purpose.

(c) After evaluation, a recommendation will be made to the State Board of Education those applications determined to be eligible for funding.

(d) As a final report, each grantee shall agree to send an Oklahoma Cost Accounting System printout for the appropriate code showing proper expenditure of funds. Data collected will be compiled and submitted as requested by the State Department of Education. Grant funds spent for purposes or items other than those approved by the State Board of Education or the grant administrator will be withheld in like amount in ~~state aid~~AP Incentive funds to that district. For the purpose of this funding opportunity, "materials" are defined as instructional items (i.e., books, manipulatives, etc.) and "equipment" is any necessary device (i.e., graphing calculators and overhead models, etc.) directly related to Advanced Placement or International Baccalaureate course(s).

[OAR Docket #10-771; filed 5-6-10]

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

[OAR Docket #10-797]

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Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
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(Reference APA WF # 09-73)
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ANALYSIS:
Rules are revised to increase co-payments for certain medical services provided through SoonerCare. Under Section 1902(a)(14) of the Social Security Act, States are permitted to require certain members to share some of the cost of their health care by imposing upon them such payments as enrollment fees, premiums, deductibles, co-insurance, co-payments, or similar cost sharing charges. The Centers for Medicare and Medicaid Services excludes the States from requiring cost sharing for children, pregnant women and institutionalized individuals as well as for emergency and family planning services. According to Article 10, Section 23 of the Oklahoma Constitution, all state agencies must maintain a balanced budget. In order for the Agency to accomplish the necessary financial reductions, rules are in need of revision to increase the existing co-payments for some services for certain SoonerCare members.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and Cost Sharing

(a) **Definitions.** The following words and terms, when used in subsection (c) of this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is

the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the ~~Primary Care Case Manager~~ SoonerCare Choice contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the ~~Primary Care Case Manager~~ SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The ~~Authority's~~ OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or ~~copayment~~ co-payment required by the State Plan to be paid by the ~~recipient~~ member and make no additional charges to the ~~patient~~ member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the ~~patient~~ member must not be billed and the ~~patient~~ member is not responsible for any balance except the amount indicated by OHCA. The only amount a ~~patient~~ member may be responsible for is ~~the personal participation as agreed to at the time of determination of eligibility~~ a co-payment, or the ~~patient~~ member may be responsible for services not covered under the medical programs. ~~The amount of personal participation will be shown on the OHCA notification of eligibility.~~ In any event, the ~~patient~~ member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, ~~Customer~~ Provider Services.

(3) When potential assignment violations are detected, the ~~Authority~~ OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the ~~Authority~~ OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the ~~Primary Care Case Management~~ SoonerCare Choice program ~~shall~~ must adhere to the rules of this subsection regarding assignment.

~~(1) If the service provided to the recipient is within the scope of the services outlined in the SoonerCare Contract, the recipient shall not be billed for the service. In this case, the provider shall pursue collection from the Primary Care Physician in the case of the SoonerCare Program.~~

(~~2~~ 1) If the service provided to the ~~recipient~~ member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the ~~recipient~~ member.

(~~3~~ 2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) ~~and (2)~~ of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.

(~~4~~ 3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain ~~recipients~~ members to share some of the costs of ~~Medicaid~~ SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, ~~copayments~~ co-payments, or similar cost sharing charges. OHCA requires a ~~copayment~~ co-payment of some ~~Medicaid recipients~~ SoonerCare members for certain medical services provided through the fee for service program. A ~~copayment~~ co-payment is a charge which must be paid by the ~~recipient~~ member to the service provider when the service is covered by ~~Medicaid~~ SoonerCare. Section 1916(e) of the Act requires that a provider participating in the ~~Medicaid~~ SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the ~~copayment~~ co-payment. A person's assertion of their inability to pay the copayment co-payment establishes this inability. This rule does not change the fact that a ~~recipient~~ member is liable for these charges and it does not preclude the provider from attempting to collect the ~~copayment~~ co-payment.

(1) ~~Copayment~~ Co-payment is not required of the following ~~recipients~~ members:

(A) Individuals under age 21. Each ~~recipient's~~ member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) ~~Recipients~~ Members in nursing facilities and intermediate care facilities for the mentally retarded.

(C) Pregnant women.

(D) Home and Community Based ~~Waiver service recipients~~ Service waiver members except for prescription drugs.

(2) ~~Copayment~~ Co-payment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(3) ~~Copayments required include~~ Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) ~~$3.00 per day for inpatient~~ Inpatient hospital ~~services~~ stays. ~~Copayments for inpatient care paid under the Diagnosis Related Groups (DRG) methodology are calculated on the actual length of stay and are capped at $90. Copayments for claims paid under Level of Care methodology are calculated at $3.00 per day.~~

(B) ~~$3.00 per day for outpatient~~ Outpatient hospital ~~services~~ visits.

(C) ~~$3.00 per day for ambulatory~~ Ambulatory surgery ~~services~~ visits including free-standing ambulatory surgery centers.

(D) ~~$1.00 for each service rendered by~~ Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(~~ii~~ iv) Optometrists,

(~~iii~~ v) Home Health Agencies,

~~(iv) Rural Health Clinics,~~

(~~v~~ vi) Certified Registered Nurse Anesthetists, and

(~~vi~~ vii) ~~Federally Qualified Health Centers.~~ Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(i) Zero for preferred generics.

(~~i~~ ii) ~~$1.00~~ $2.00 for prescriptions having a ~~Medicaid~~ SoonerCare allowable of $29.99 or less.

(~~ii~~ iii) ~~$2.00~~ $3.00 for prescriptions having a ~~Medicaid~~ SoonerCare allowable of $30.00 or more.

(F) Crossover claims. Dually eligible ~~Medicare/Medicaid recipients~~ Medicare/SoonerCare members must make a ~~copayment~~ co-payment ~~of $.50~~ in an amount that does not exceed the federal allowable per ~~service~~ visit/encounter for all Part B covered services. This does not include dually eligible ~~HCBW service recipients~~ HCBS waiver members.

[OAR Docket #10-797; filed 5-7-10]

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

[OAR Docket #10-795]

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PERMANENT final adoption
RULES:
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
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Subchapter 5. Individual Providers and Specialties
Part 51. Habilitation Services
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ANALYSIS:
Agency rules are revised to clarify provider eligibility requirements for Home and Community Based Services providers for persons with mental retardation or certain persons with related conditions. Additionally rules are amended to clarify the provision of dental services funded through the Home and Community Based Waiver; revise language relating to nutrition services; specify coverage limitations for occupational therapy services; specify that physical therapists and physical therapist assistants must have a non restricted license to provide services through the Home and Community Based Waiver; limit HTS providers residing in the same home as the member to no more than 40 hours per week of paid supports and direct members with a need for support greater than 40 hours per week to access the remainder of their support from staff residing outside of their home; clarify that HTS may not perform functions relating to other employment during the provision of HTS services; and clarify the services that can not be simultaneously provided during the time pre-vocational and supported employment services are being rendered.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

(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 (OKDHS) Developmental Disabilities Services Division (DDSD) 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. Oklahoma Medicaid is referred to hereinafter as SoonerCare.

(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~~ SoonerCare 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~~ SoonerCare 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~~ a current provider agreement with OHCA to provide HCBS for persons with mental retardation or related conditions.

(1) All providers, except pharmacy, specialized medical supplies and durable medical equipment providers must be reviewed by OKDHS DDSD. The review process verifies:

(A) the provider meets the licensure, certification or other standards as specified in the approved HCBS Waiver documents; and

(B) organizations that do not require licensure wishing to provide HCBS services meet program standards, are financially stable and use sound business management practices.

(2) Providers who do not meet the standards in the review process will not be approved for a provider agreement.

(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(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 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through ~~(13)~~ (15). Providers of any habilitation service must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS).

(1) **Dental services.** Dental services are provided per OAC 317:40-5-112.

(A) **Minimum qualifications.** Providers of dental services must have non-restrictive licensure to practice dentistry in Oklahoma by the Board of Governors of Registered Dentists of Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) oral examination;

(ii) bite-wing x-rays;

(iii) prophylaxis;

(iv) topical fluoride treatment;

(v) development of a sequenced treatment plan that prioritizes~~;~~:

(I) elimination of pain;

(II) adequate oral hygiene; and

(III) restoration or improved ability to chew;

(vi) routine training of member or primary caregiver regarding oral hygiene; and

(vii) ~~any other service recommended by a dentist~~ preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable per OAC 317:40-5-112.

(C) **Coverage limitations.** 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. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

~~(A) **Minimum qualifications.** Providers of nutrition services must be licensed by the Oklahoma State~~

~~Board of Medical Examiners and registered as a dietitian with the Commission of Dietetic Registration.~~

~~(B) **Description of services.** Nutrition services include dietary evaluation and consultation in diet to members or their caregivers.~~

~~(i) Services are:~~

~~(I) intended to maximize the member's nutritional health; and~~

~~(II) provided in any community setting as specified in the 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 per Plan of Care year.~~

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current non-restrictive 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.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of their practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the 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, and physician assistants~~, and advanced practice nurses~~ in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the 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. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

~~(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 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~~ have a current non-restrictive ~~licensed~~ licensure 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.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapy assistants, within the limits of their practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the 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, and physician assistants~~, and advanced practice nurses~~ in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapy assistant within their employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

~~(i) Payment is made for:~~

~~(I) compensable services to the individual physical therapist for direct services; or~~

~~(II) services provided by a qualified physical therapy assistant within 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 per Plan of Care year; and~~

~~(II) 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. Service is provided in any community setting as specified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group, six person maximum, 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:

(I) Description: Psychotherapy services and behavior treatment services (individual): Unit: 15 minutes; and

(II) Description: Cognitive/behavioral treatment (group): Unit: 15 minutes.

(ii) Psychological services are authorized for a period not to exceed six months.

(I) Initial authorization is through the Developmental Disabilities Services Division (DDSD) case manager, with review and approval by the DDSD case management supervisor.

(II) Initial authorization must not exceed 192 units (48 hours of service).

(III) Monthly progress notes must include a statement of hours and type of service provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) If progress notes are not submitted to the DDSD case manager for each month of service provision, authorization for payment must be withdrawn until such time as progress notes are completed.

(iii) Treatment extensions may be authorized by the DDSD area manager based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDSD case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human Services (OKDHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours (96 units) of service per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours (48 units) may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours (560 units) of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a provider of psychiatric services requires a non-restrictive license to practice medicine in 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 management and consultation provided to members who are eligible. Services are provided in any community setting as specified in the member's IP.

(i) Services are intended to contribute to the 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, with a limit of 200 units 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. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the 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, and 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, with a limit of 288 units per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the OKDHS DDSD sanctioned training curriculum. 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 services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based 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. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members who require more than 40 hours per week of HTS must use staff members who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of any necessary support staff hours.

(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) DDSD case management supervisor review and approval is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an oversight agency approved by the OHCA. For pre-authorized HTS services, the service:

(I) provider will receive oversight from DDSD area staff; and

(II) must be pre-approved by the DDSD director or designee.

(C) **Coverage limitations.** HTS services are 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) A unit is 15 minutes.

(ii) Individual HTS services providers will be limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same 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.

(vi) HTS providers may not perform any job duties associated with other employment including on call duties, at the same time they are providing HTS services.

(9) **Self Directed HTS (SD HTS).** SD HTS are provided per 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).** SD GS are provided per 317:40-9-1.

(~~9~~11) **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 to members who are eligible. Services are intended to maximize the member's auditory receptive abilities. 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, and 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.** Audiology services are provided in accordance with the ~~service recipient's~~ member's IP.

(~~10~~12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services 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 or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** 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 at 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 must 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 payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed $25,000 per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training and as allowed per 317:40-7-6.

(~~11~~13) **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 or 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 employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does 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 must be maintained in the record of each member receiving this service.

(v) Federal financial participation (FFP) may 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 are 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 DDSD case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member at the same time as supported employment services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) Therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(~~12~~14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current~~, valid contracts~~ provider agreement with OHCA and OKDHS DDSD. 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) IPS:

(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) build upon the level of support provided by a HTS or 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) DDSD case management supervisor review and approval is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP per OAC 317:40-5-151 and 317:40-5-153.

(~~13~~15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements set forth in 63 O.S. ' 1-873 *et seq*. and comply with OAC 310:605; and

(ii) be approved by the OKDHS DDSD and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive, and socialization skills, including the opportunity to interact with peers 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.** 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 member's IP.

[OAR Docket #10-795; filed 5-7-10]

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

[OAR Docket #10-798]

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PERMANENT final adoption

RULES:
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-57. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part. 5 Pharmacies
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(Reference APA WF # 09-74)

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N/A
ANALYSIS:
Agency rules are revised to change the script limit for SoonerCare members from three brand drugs and three generic to two brand drugs and four generic. The revisions are needed in order to reduce the Agency's budget to comply with the legislative mandated budget reductions.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare ~~coverages~~ coverage guidelines for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity Clinic Services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.

(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC ~~317: 30-5-95~~ 317:30-5-95 through OAC 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services

(B) Optometrists' services

(C) Psychologists' services

(D) Certified Registered Nurse Anesthetists

(E) Certified Nurse Midwives

(F) Advanced Practice Nurses

(G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six prescriptions with a limit of ~~three~~ two brand name prescriptions per month. Exceptions to the six prescription limit are:

(A) unlimited medically necessary monthly prescriptions for:

(i) members under the age of 21 years; and

(ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.

(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the ~~three~~ two brand name or thirteen total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/MR's.

(21) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under age 21.

(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.

(23) Standard medical supplies.

(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal.

(25) Blood and blood fractions for members when administered on an outpatient basis.

(26) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.

(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60

days after the pregnancy ends, beginning on the last date of pregnancy.

(31) Nursing facility services for members under 21 years of age.

(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.

(33) Part A deductible and Part B ~~medicare~~ Medicare Coinsurance and/or deductible.

(34) Home and Community Based Waiver Services for the mentally retarded.

(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.

(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(D) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(E) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for mentally retarded members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).

(38) Case Management services for the chronically and/or severely mentally ill.

(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.

(41) Early Intervention services for children ages 0-3.

(42) Residential Behavior Management in therapeutic foster care setting.

(43) Birthing center services.

(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.

(45) Home and Community-Based Waiver services for aged or physically disabled members.

(46) Outpatient ambulatory services for members infected with tuberculosis.

(47) Smoking and Tobacco Use Cessation Counseling for children and adults.

(48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six covered prescriptions per month with a limit of ~~three~~ two brand name prescriptions.

(2) Subject to the limitations set forth in OAC 317:30-5-72.1, OAC 317:30-5-77.2, and OAC 317:30-5-77.3, exceptions to the six medically necessary prescriptions per month limit are:

(A) unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded; and

(B) seven additional medically necessary prescriptions which are generic products per month to the six covered under the State Plan are allowed for adults receiving services under the 915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the ~~three~~ two brand name or thirteen total prescriptions will be covered with prior authorization.

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(b) **Coverage for children.** Prescription drugs for SoonerCare eligible individuals under 21 years of age are not limited.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part

D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. The exclusion will become effective January 1, 2006, or the date Medicare Part D is implemented for dual eligible individuals, whichever is later. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

[OAR Docket #10-798; filed 5-7-10]

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

[OAR Docket #10-781]

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317:30-3-60. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-2. [AMENDED]
317:30-5-9. [AMENDED]
Part 3. Hospitals
317:30-5-42.17. [AMENDED]
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Rules are revised to include a new provider type - Anesthesiologist Assistant (AA), as allowed by the Oklahoma Anesthesiologist Assistant Act. AA's will be allowed to perform anesthesiologist services under the direct supervision of a licensed anesthesiologist. General coverage rules are revised to make OHCA rules consistent with reimbursement practices and make coverage rules more consistent throughout policy. Revisions include allowing separate payment for the insertion and/or implantation of contraceptive devices during a physician office visit, the removal of physician supervision of hemodialysis or peritoneal dialysis as a general coverage exclusion for both adults and children, the clarification of intent in regards to general coverage and general coverage exclusions for both adults and children, the removal of follow-up consultations, the removal of tympanometry as a general coverage exclusion for children, the clarification of covered critical care guidelines, and general policy cleanup as it relates to these sections.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:

(1) Inpatient admission for 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~~ member 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~~ member's care, the procedure codes for subsequent hospital care ~~should~~ must be used.
(4) Refractions and visual aids.
(5) ~~A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care~~ Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(6) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or ~~Reversal~~ reversal of sterilization procedures for the purposes of conception.
(7) ~~Non-therapeutic~~ 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.~~
(8) 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. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(9) Medical services considered ~~to be~~ experimental or investigational.
(10) Services of a Certified Surgical Assistant.
(11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.
(12) Services of an independent licensed Physical and/or Occupational Therapist.
(13) Services of a Psychologist.
(14) Services of an independent licensed Speech and Hearing Therapist.
(15) Payment for more than four outpatient visits per month (home~~,~~ or office~~, outpatient hospital~~) per ~~patient~~ member, except those visits in connection with family planning or related to emergency medical ~~condition~~ conditions.
(16) Payment for more than two nursing ~~home~~ facility visits per month.
(17) More than one inpatient visit per day per physician.
(18) Payment for removal of benign skin lesions unless medically necessary.
(19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(22) Mileage.
(23) A routine hospital visit on the date of discharge unless the member expired.
(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

317:30-3-60. General program exclusions - children

(a) The following are excluded from ~~Medicaid~~ SoonerCare coverage for children:
(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Services or any expense incurred for cosmetic surgery~~,~~ unless the physician certifies the procedure emotionally necessary ~~for the emotional well-being of the patient~~.
(3) Services of two physicians for the same type of service to the same ~~patient~~ member 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~~ member's care, the procedure codes for subsequent hospital care ~~should~~ must be used.
(4) ~~Separate payment for post-operative care when payment is made for surgery~~ Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery

guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(5) Sterilization of ~~persons~~ members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(6) ~~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~~ Non-therapeutic hysterectomies.

(7) 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. (See OAC 317:30-5-6 or 317:30-5-50).

(8) Medical services considered ~~to be~~ experimental or investigational.

(9) Services of a Certified Surgical Assistant.

(10) Services of a Chiropractor.

~~(11) Services of a Registered Physical Therapist.~~

(~~12~~ 11) More than one inpatient visit per day per physician.

(12) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(13) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(14) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(15) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(16) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(17) Mileage.

(18) A routine hospital visit on date of discharge unless the member expired.

(b) Not withstanding the exclusions listed in (1)-~~(12)~~ (18) of subsection (a), the Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT) provides for coverage of needed medical services normally outside the scope of the medical program when performed in connection with an EPSDT screening and prior authorized.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA's) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory ~~surgi-center~~ surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services. Refer to the Medicare approved list of covered services that can be performed at an ASC ~~List of Covered Surgical Procedures~~.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.

(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare ~~patient~~ member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is

allowed for a separately identifiable service unrelated to the dialysis.

(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for ~~I.U.D. insertion~~ the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling ~~(requires special medical review prior to approval)~~.

~~(Q) Weekly blood counts for members receiving the drug Clozaril.~~

~~(R) Complete blood count (CBC) and platelet count prior to receiving chemotherapeutic agents, radiation therapy or medication such as DPA-D-Penacillamine on a regular basis for treatment other than for malignancy.~~

(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.

(~~S~~ R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(~~T~~ S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(~~U~~ T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(~~V~~ U) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and ~~sign~~ signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(~~W~~ V) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

(~~X~~ W) The ~~Payment~~ payment to a physician for ~~supervision~~ medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited ~~services unless the CRNA bills directly~~. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(~~Y~~ X) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(~~Z~~ Y) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(iv) Procedures considered experimental or investigational are not covered.

(~~AA~~ Z) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.

(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(~~BB~~ AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(~~CC~~ BB) Ventilator equipment.

(~~DD~~ CC) Home dialysis equipment and supplies.

(~~EE~~ DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(~~FF~~ EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(~~GG~~ FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member 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 member's status.~~ If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.

(D) Refractions and visual aids.

(E) ~~A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care~~ Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic ~~hysterectomy~~ hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning~~,~~ or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

~~(M) Physician supervision of hemodialysis or peritoneal dialysis.~~

(~~N~~ M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(~~O~~ N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(~~P~~ O) Payment for the services of ~~physicians' assistants,~~ social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(~~Q~~ P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury~~,~~ or illness, ~~related to~~ 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 ~~when~~ that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

~~(R) Night calls.~~

(~~S~~ Q) Speech and Hearing services.

(~~T~~ R) Mileage.

(~~U~~ S) A routine hospital visit on the date of discharge unless the member expired.

(~~V~~ T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(~~W~~ U) Inpatient chemical dependency treatment.

(~~X~~ V) Fertility treatment.

(~~Y~~ W) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) ~~Effective October 1, 1993, all~~ All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for 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) Services of two physicians for the same type of service to the same member 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 member's status.~~ If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.

(D) ~~A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care~~ Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of ~~persons~~ members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) ~~Non-therapeutic hysterectomy.~~ Non-therapeutic hysterectomies.

(H) Medical Services considered experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) 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. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

~~(K) Physician supervision of hemodialysis or peritoneal dialysis.~~

(~~L~~ K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(~~M~~ L) Payment for the services of ~~physicians' assistants~~ social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(~~N~~ M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(~~O~~ N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

~~(P) Night calls.~~

(~~Q~~ O) Mileage.

(~~R~~ P) A routine hospital visit on date of discharge unless the member expired.

~~(S) Tympanometry.~~

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment or within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment or within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four office visits (or home) per month per member, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

(3) Payment is allowed for ~~insertion of IUD~~ the insertion and/or implantation of contraceptive devices in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials

(B) Dressing for burns

(C) ~~Intrauterine device~~ Contraceptive devices

(D) IV Fluids

~~(E) Medications administered by IV~~

~~(F) Glucose administered IV in connection with chemotherapy in office~~

(5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.

(6) Medically necessary office lab and X-rays are covered.

(7) Hearing exams by physician for members between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

(8) Hearing aid evaluations are covered for members under 21 years of age.

(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

(10) Payment is made for both an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.

(11) Payment is made for an office visit in addition to allergy testing.

(12) Separate payment is made for antigen.

(13) Eye exams are covered for members between ages 21 and 65 for medical diagnosis only.

(14) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

(15) Separate payment is made for the following specimen collections:

(A) Catheterization for collection of specimen; and

(B) Routine Venipuncture.

(16) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

(17) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for ~~night calls, unusual hours or~~ mileage.

(5) Payment is not made for an office visit where the member did not keep appointment.

(6) Refractive services are not covered for persons between the ages of 21 and 65.

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved. 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 member's status.~~ If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care ~~are~~ must be used.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day ~~and 4 units per month~~. ~~Payment for critical care, each additional 30 minutes is limited to two units per day/month.~~

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two nursing ~~home~~ facility visits per month. The appropriate CPT code is used.

(3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

PART 3. HOSPITALS

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 admission for 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 or investigational.

(5) Payment for removal of benign skin lesions unless medically necessary.

(6) Refractions and visual aids.

(7) Charges incurred while ~~patient~~ the member is in a skilled nursing or swing bed.

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

[OAR Docket #10-800]

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(Reference APA WF # 09-77)
INCORPORATIONS BY REFERENCE:
N/A
ANALYSIS:
Agency rules are written to establish policy for hospital acquired conditions and for serious reportable events in healthcare, also called never events. Rules will set policy to no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. Payment will be made as though the secondary diagnosis was not present. The selected conditions that OHCA will recognize are those conditions identified as non-payable by Medicare. Additionally, rules will non-cover three surgical errors and set billing policy to implement appropriate claims processing. The three surgical errors are (1) wrong surgical or other invasive procedures performed on a member, (2) surgical or other invasive procedures performed on the wrong body part, and (3) surgical or other invasive procedures performed on the wrong member. Rules will also include a related claims review (if appropriate) and the avoidance of SoonerCare to act as a secondary payer for Medicare non-payment.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-62. Serious reportable events - never events

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) **"Surgical and other invasive procedures"** are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

(2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.

(3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

(4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.

(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.

(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the applicable HCPCS modifiers will be line-item denied.

(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).

(f) **Hospital acquired conditions.** SoonerCare will not reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. See OAC 317:30-3-63 for specific information regarding hospital acquired conditions.

317:30-3-63. Hospital acquired conditions

(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. The claim will be grouped to a DRG as if the diagnosis was not present on the claim. The selected conditions that OHCA recognizes are those conditions identified as non-payable by Medicare. OHCA may revise through addition or deletion the selected conditions at any time during the fiscal year. The following is a complete list of the hospital acquired conditions (HACs) currently recognized by OHCA:

(1) Foreign Object Retained After Surgery
(2) Air Embolism
(3) Blood Incompatibility
(4) Pressure Ulcer Stages III & IV
(5) Falls and Trauma
  (A) Fracture
  (B) Dislocation
  (C) Intracranial Injury
  (D) Crushing Injury
  (E) Burn
  (F) Electric Shock
(6) Catheter-Associated Urinary Tract Infection
(7) Vascular Catheter-Associated Infection
(8) Manifestations of Poor Glycemic Control
  (A) Diabetic Ketoacidosis
  (B) Nonketotic Hyperosmolar Coma
  (C) Hypoglycemic Coma
  (D) Secondary Diabetes with Ketoacidosis
  (E) Secondary Diabetes with Hyperosmolarity
(9) Surgical Site Infection Following:
  (A) Coronary Artery Bypass Graft- Mediastinitis
  (B) Bariatric Surgery
    (i) Laparoscopic Gastric Bypass
    (ii) Gastroenterostomy
    (iii) Laparoscopic Gastric Restrictive Surgery
  (C) Orthopedic Procedures
    (i) Spine
    (ii) Neck
    (iii) Shoulder
    (iv) Elbow
(10) Deep Vein Thrombosis and Pulmonary Embolism
  (A) Total Knee Replacement
  (B) Hip Replacement

(b) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a present on admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator.

(c) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned hospital acquired conditions.

[OAR Docket #10-800; filed 5-7-10]

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

[OAR Docket #10-794]

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N/A
ANALYSIS:
Agency rules are revised to comply with CMS SHO #09-111 requiring all State Medicaid agencies to reimburse a vaccine administration fee to all Medicaid contracted providers administering the 2009 H1N1 vaccine to eligible population. Currently, rules only allow for reimbursement for vaccine administration in limited circumstances. Revisions allow for reimbursement of an administration fee for pandemic virus vaccines administered to eligible SoonerCare members following a declaration by the Centers for Disease Control of a pandemic virus. Revisions also allow for an administration fee to be paid to providers administering the Human Papillomavirus (HPV) vaccine to eligible SoonerCare members.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

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 SoonerCare. SoonerCare payment is not available for injectable drugs whose manufacturers have not entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS). OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) subject to the exclusions and limitations provided in OAC 317:30-5-72.1.

(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 provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines. A separate payment will not be made for the administration of a vaccine unless specifically outlined in policy. The administration fee is included in the vaccine payment.

(b) Providers must use ~~Use~~ the appropriate HCPCS code and National Drug Code (NDC). In addition to the NDC and HCPCS code, claims must contain the drug name, strength, and dosage amount.

(c) 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 member. When the allergy antigen is purchased by the physician, payment is made by invoice attached to the claim.

(d) 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.

(e) Human Papillomavirus (HPV) vaccine is approved and covered under guidelines established by the ACIP for children and adults. Payment can be made separately to the physician for administration and the vaccine product.

(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.

(~~f~~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.

(~~g~~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.

(~~h~~i) Intravenous fluids used in the administration of IV drugs are covered. Payment for the set is included in the office visit reimbursement.

(j) In the event a pandemic virus is declared by the Centers for Disease Control (CDC) and/or the Department of Health & Human Services, an administration fee will be paid to providers for administering the pandemic virus vaccine to adults and children as authorized by the Centers for Medicare and Medicaid Services (CMS).

[OAR Docket #10-794; filed 5-7-10]

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

[OAR Docket #10-783]

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Part 7. Certified Laboratories
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ANALYSIS:
Agency rules are revised to clarify that reimbursement is only made for medically necessary laboratory services. Additional revisions include removing language which calls for OHCA to edit laboratory claims at the specialty/subspecialty level. CMS only allows edits for SoonerCare claims at the CLIA certificate level. Other revisions include general policy cleanup as it relates to these sections.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Covered lab services.** Providers may be paid for covered clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) ~~Effective September 1, 1992, reimbursement~~ Reimbursement for lab 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, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from ~~HCFA~~ CMS and have a current contract on file with the OHCA. ~~Payment is made only for those services which fall within the approved specialties/subspecialties.~~

(B) ~~Effective May 1, 1993, reimbursement~~ Reimbursement rate for laboratory procedures is the lesser of the ~~HCFA~~ CMS National 60% fee or the local carrier's allowable (whichever is lower).

(C) ~~All claims for laboratory services are considered medically necessary unless specifically disallowed in this Chapter~~ Medically necessary laboratory services are covered.

(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered. ~~Genetic counseling requires special medical review prior to approval.~~

(3) **~~Noncompensable~~ Non-compensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(C) Laboratory services not considered medically necessary are not covered.

(4) **Covered services by a pathologist.**

(A) A pathologist may be paid for interpretation of inpatient surgical pathology specimen. The appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

(5) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Tissue examinations for identification of teeth and foreign objects.

(B) Experimental or investigational procedures.

(C) Interpretation of clinical laboratory procedures.

PART 7. CERTIFIED LABORATORIES

317:30-5-100. Eligible providers

~~Effective September 1, 1992, reimbursement~~ Reimbursement for lab 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, including those furnished in physicians' offices. Regulations specify that any and every facility which tests human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or impairment of, or the assessment of the health of human beings is subject to CLIA. All facilities which perform these tasks must make application for certification by ~~HCFA~~ CMS. Eligible ~~Medicaid~~ SoonerCare providers must be certified under the CLIA program and have obtained a ~~CLIAID~~ CLIA ID number from ~~HCFA~~ CMS and have a current contract on file with ~~this Authority~~ the OHCA. ~~Payment is made only for those services which fall within the approved specialties/subspecialties.~~

[OAR Docket #10-783; filed 5-7-10]

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

[OAR Docket #10-799]

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317:30-5-211.12. [AMENDED]
317:30-5-211.15. [AMENDED]
317:30-5-218. [AMENDED]
Part 61. Home Health Agencies
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N/A
ANALYSIS:
Durable medical equipment (DME) rules are revised to reduce and/or eliminate certain durable medical equipment benefits to adults in order to comply with the budget reductions mandated by the Oklahoma Legislature through the end of State Fiscal Year 2010. Revisions include the elimination of osteogenic stimulators, portable oxygen contents, the reduction of blood glucose strips and lancets without a prior authorization, and flexibility in the agency's reimbursement terminology.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

317:30-5-211.10. Durable medical equipment (DME)

(a) **DME.** DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment and other qualifying items when acquired from a contracted DME provider.

(b) **Certificate of medical necessity.** Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include but are not limited to:

(1) hospital beds;
(2) support surfaces;
~~(3) wheelchairs;~~
(~~4~~ 3) continuous positive airway pressure devices (~~Bi-CAP~~ BiPAP and CPAP);
(~~5~~ 4) patient lift devices;
(~~6~~ 5) external infusions pumps;
(~~7~~ 6) enteral and parenteral nutrition; and
~~(8) osteogenesis stimulators; and~~
(~~9~~ 7) pneumatic compression devices.

(c) **Prior authorization.**

(1) **Rental.** Rental of hospital beds, support surfaces, ~~wheelchairs,~~ continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record and be signed by the physician.

(2) **Purchase.** Equipment will be purchased when a member requires the equipment for an extended period of time. During the prior authorization review the PA consultant may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Oxygen concentrators are covered items for members residing in their home or in a nursing facility.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems ~~and portable oxygen content~~. Portable oxygen contents are not covered. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a ~~standby~~ backup system only is not a covered item.

(3) When six or more liters of oxygen are medically necessary, an additional payment will be paid up to 150% of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-211.15. Supplies

(a) The OHCA provides coverage for supplies that are prescribed by the appropriate medical provider, medically necessary and meet the special requirements below.

(b) Special requirements:

(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.

(2) **Diabetic supplies.** ~~The purchase of one glucometer, one spring loaded lancet device, and replacement batteries as defined by the life of the battery are covered items. In addition, a~~ A maximum of ~~200~~ 100 glucose test strips and ~~200~~ 100 lancets per month when medically necessary and prescribed by a physician are covered items. Diabetic supplies in excess of these parameters must be prior authorized.

(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.

(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.

317:30-5-218. Reimbursement

(a) **Medical equipment and supplies.** Reimbursement for durable medical equipment and supplies will be made using an amount derived from the lesser of the OHCA maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established ~~based on efficiency, economy, and quality of care as determined by the OHCA~~. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(b) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. ~~Content for portable systems should be billed monthly with one unit equal to one month's supply.~~ Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) ~~Effective July 1, 2007, payment~~ Payment for oxygen and ~~for~~ oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code ~~be based on the Medicaid allowable in effect for the Oklahoma region on June 30, 2007~~. Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually~~;~~ and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

PART 61. HOME HEALTH AGENCIES

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. Reimbursement for any combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the OHCA fee schedule or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code. When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established ~~based on efficiency, economy, and quality of care as determined by the OHCA~~. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. ~~Content for portable systems should be billed monthly with one unit equal to one month's supply.~~ Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) ~~Effective July 1, 2007, payment~~ Payment for oxygen and ~~for~~ oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code ~~be based on the Medicaid allowable in effect for the Oklahoma region on June 30, 2007~~. Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually~~;~~ and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

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CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

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N/A
ANALYSIS:
Outpatient hospital rules are revised to clarify the intent of reimbursement for implantable devices inserted during the course of a surgical procedure. Separate payment will be made for implantable devices, but only when the implantable device is not included in the rate for the procedure to insert the device. Additional revisions include removing all-inclusive reimbursement language for outpatient radiological services and additional clarification in regards to adult therapies performed in an outpatient hospital based setting.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

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 all inclusive payment rate on a per visit basis which is paid to the hospital~~ covered.

(2) The professional component of x-rays performed during an emergency department visit is covered.

(3) Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A-C).

(4) 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 ~~sterotactic~~ stereotactic radiosurgery (e.g.,gamma knife).

(5) Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.

(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 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 must still be inpatient hospital, since the 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 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 is made at 100% of the invoice charges. Fee must include cost of radium, container, and shipping and handling.

PART 3. HOSPITALS

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).

(d) Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(e) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital based setting. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

[OAR Docket #10-788; filed 5-7-10]

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

[OAR Docket #10-782]

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RULES:
Subchapter 5. Individual Providers and Specialties
Part 4. Long Term Care Hospitals
317:30-5-65. [AMENDED]
Part 17. Medical Suppliers
317:30-5-211.17. [NEW]
(Reference APA WF # 09-32)
AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Consumer Protection for Wheeled Mobility Act, Section 1015.3 of Title 56 of Oklahoma Statutes
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INCORPORATIONS BY REFERENCE:
N/A
ANALYSIS:
Rules are revised to comply with the Consumer Protection for Wheeled Mobility Act found at 56 O.S. 1015.3. The Act requires either a specialty evaluation or direct in-person involvement in the wheelchair selection process by an Assistive Technology Professional (ATP) for all wheelchairs purchased by SoonerCare. Prior to this act, there has been no requirement for suppliers to show competence in matching members with the right wheelchair. Many members spend all day in their wheelchairs and the common problems caused by getting the wrong chair include orthopedic deformation and pressure sores that are painful, debilitating, and slow and costly to heal.

Rules are revised to make DME rules consistent with reimbursement practices and provide consistency throughout policy. Revisions include clarifying the intent of wheelchair coverage for members residing in a long term care facility or ICF/MR and the elimination of the OHCA Certificate of Medical Necessity as a document requirement for requesting prior authorization or determining medical necessity for wheelchairs.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 4. LONG TERM CARE HOSPITALS

317:30-5-65. Ancillary services

Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:

(1) Services requiring prior authorization:

(A) Ventilators and supplies.

(B) Total Parenteral Nutrition (TPN), and supplies.

(C) ~~Custom wheelchairs~~ Custom seating for wheelchairs.

(D) Enteral feeding.

(2) Services not requiring prior authorization:

(A) Permanent indwelling or male external catheters and catheter accessories.

(B) Colostomy and urostomy supplies.

(C) Tracheostomy supplies.

(D) Prescription drugs, laboratory procedures, and x-rays.

PART 17. MEDICAL SUPPLIERS

317:30-5-211.17. Wheelchairs

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) **"Assistive technology professional"** or **"ATP"** means a for-service provider who is involved in analysis of the needs and training of a consumer in the use of a particular assistive technology device or is involved in the sale and service of rehabilitation equipment or commercially available assistive technology products and devices.

(2) **"Custom seating system"** means a wheelchair seating system which is individually made for a member using a plaster model of the member, a computer generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the member to create either:

(A) a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or,

(B) a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

(3) **"RESNA"** means the Rehabilitation Engineering and Assistive Technology Society of North America.

(4) **"Specialty evaluation"** means the determination and documentation of the consumer's pathology, history and prognosis, and the physiological, functional, and environmental factors that impact the selection of an appropriate wheeled mobility system.

(b) **Medical Necessity.** Medical necessity pursuant to OAC 317:30-5-211.2 is required for a wheelchair to be covered and reimbursed by SoonerCare.

(c) **Prior authorization.** Prior authorization pursuant to OAC 317:30-5-211.3 is required for a wheelchair to be covered and reimbursed by SoonerCare. All prior authorization requests for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.

(1) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the member to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(2) Certain wheelchair parts, accessories, and/or modifications that are distinctly and separately requested and priced from the original wheelchair request require prior authorization.

(3) OHCA will deny prior authorization requests when the required forms have not been fully completed or the member's medical record does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(d) **Coverage and limitations.**

(1) For a member who resides in a personal residence, assisted living facility, Intermediate Care Facility for the Mentally Retarded (ICF/MR) or long term care facility, the following criteria must be met for the authorization to purchase a wheelchair.

(A) The member must have a prescription signed by a physician, a physician assistant, or an advanced registered nurse practitioner.

(B) The member must meet the requirements for medical necessity as determined and approved by the Oklahoma Health Care Authority.

(C) The member must either have:

(i) a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist, occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and that documents the medical necessity for the wheelchair and its special features; or

(ii) a wheelchair provided by a supplier that employs a RESNA certified assistive technology professional who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the member.

(2) For members who reside in a long term care facility or ICF/MR, only custom seating systems for wheelchairs are eligible for direct reimbursement to providers of DME services. All standard manual and power wheelchairs are the responsibility of the facility and are considered part of the facility's per diem rate.

(e) **Rental, repairs, maintenance and delivery.** Refer to OAC 317:30-5-211.4 through 317:30-5-211.5.

(f) **Documentation.**

(1) The specialty evaluation or wheelchair selection documentation must be submitted with the prior authorization request.

(2) The specialty evaluation or wheelchair selection must be performed no longer than 90 days prior to the submission of the prior authorization request.

(3) The results of the specialty evaluation or wheelchair selection documentation must be supported by the information submitted on the member's medical record.

(4) A copy of the dated and signed written specialty evaluation or wheelchair selection document must be maintained by the wheelchair provider. The results of the specialty evaluation or wheelchair selection must be written, signed and dated by the medical professional who evaluated the member or the ATP who was involved in the wheelchair selection for the member.

[OAR Docket #10-782; filed 5-7-10]

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

[OAR Docket #10-787]

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Part 63. Ambulatory Surgical Centers (ASC)
317:30-5-566. [AMENDED]
317:30-5-567. [AMENDED]
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10-174
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N/A
ANALYSIS:
Ambulatory Surgery Center (ASC) rules are revised to allow reimbursement for services not covered as Medicare ASC procedures but otherwise covered under the SoonerCare program. Currently, policy restricts OHCA reimbursement to only those services on the Medicare approved list of covered services. This revision will give OHCA additional flexibility in determining services which are appropriate for the populations we serve.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 63. AMBULATORY SURGICAL CENTERS (ASC)

317:30-5-566. Ambulatory Surgery Center services

(a) **Reimbursement.** Reimbursement is made for selected services based on the Medicare approved list of covered services that can be performed at an ASC. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA. Ambulatory surgery center services are paid on a rate-per-service basis that varies according to the Health Care Procedure Coding System (HCPCS) codes. Separate payments may be made to the ASC for covered ancillary services. To be considered a covered ancillary service for which separate payment is made, the items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

(b) **Multiple surgeries.** Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment rate. Fifty percent is paid for any other procedure(s) performed at the same time if the procedure is subject to discounting based on the discount indicator established by Medicare.

(c) **Payment indicators.** Payment indicators identify whether the service described by a HCPCS code is paid under the ASC methodology and if so, whether payment is made separately or packaged. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(d) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in an ambulatory surgery center unless medically necessary and they are on the Medicare list for procedures approved to be performed in an ASC. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

(e) **Dental Procedures.** For OHCA payment purposes, the ASC list has been expanded to cover dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an ambulatory surgery center is covered for children under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an ambulatory surgical center is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances:

(A) A concurrent hazardous medical condition exists;

(B) The nature of the procedure requires hospitalization; or~~;~~

(C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

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~~ Medicare's list of covered ASC surgical procedures and dental procedures in certain circumstances. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

(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 Medicare's list of covered ASC surgical procedures. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

(3) **Individuals eligible For Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services.

[OAR Docket #10-787; filed 5-7-10]

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

[OAR Docket #10-790]

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Subchapter 5. Individual Providers and Specialties
Part 65. Case Management Services for Over 21
317:30-5-585. [REVOKED]
317:30-5-586. [REVOKED]
Part 67. Behavioral Health Case Management Services ~~For Individuals Under 21 Years of Age~~
317:30-5-595. [AMENDED]
317:30-5-596. [AMENDED]
317:30-5-596.1. [AMENDED]
317:30-5-596.2. [REVOKED]
Part 97. Case Management Services for Under Age 18 At Risk of or in the Temporary Custody or Supervision of Office of Juvenile Affairs
317:30-5-972. [AMENDED]
Part 99. Case Management Services for Under Age 18 In Emergency, Temporary or Permanent Custody or Supervision of the Department of Human Services
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317:30-5-586. [REVOKED]
Part 67. Behavioral Health Case Management Services ~~For Individuals Under 21 Years of Age~~
317:30-5-595. [AMENDED]
317:30-5-596. [AMENDED]
317:30-5-596.1. [AMENDED]
317:30-5-596.2. [REVOKED]
Part 97. Case Management Services for Under Age 18 At Risk of or in the Temporary Custody or Supervision of Office of Juvenile Affairs
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Part 99. Case Management Services for Under Age 18 In Emergency, Temporary or Permanent Custody or Supervision of the Department of Human Services
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10-289
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INCORPORATIONS BY REFERENCE:
N/A
ANALYSIS:
Targeted Case Management rules are being revised to combine the over and under 21 outpatient BH TCM rules into one streamline; broaden TCM to all BA/BS level degrees to increase access across the state; adding in service definition wording to be more consistent with DMHSAS.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 65. CASE MANAGEMENT SERVICES FOR OVER 21

317:30-5-585. Eligible providers [REVOKED]

~~Services are provided by case management agencies established for the purpose of providing case management services.~~

~~(1) **Provider agency requirements.** The agency must demonstrate its capacity to deliver case management services in terms of the following:~~

~~(A) On or after July 1, 2007, the OHCA will require agencies to have accreditation appropriate to case management from JCAHO, CARE, COA, or AOA, and meet the standards of the accreditation agency at all times.~~

~~(B) The OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.~~

~~(C) Agencies that are eligible to contract with the OHCA to provide case management services for seriously mentally ill adults must be community based.~~

~~(D) Agencies must be able to demonstrate the ability to develop and maintain appropriate patient records including, but not limited to, assessments, service plans, and progress notes.~~

~~(E) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.~~

~~(F) Each site operated by a case management facility must have a separate provider number. A site is defined as an office, clinic, or other business setting where case management services are routinely performed. When services are rendered at the patient's residence, a school, or an appropriate community based setting, a site is determined according to where the professional staff conduct administrative duties and where the patient's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.~~

~~(2) **Provider types.**~~

~~(A) **ODMHSAS public and private facilities.** Public ODMHSAS facilities are regionally based Community Mental Health Centers. Private ODMHSAS facilities are providers that have contracted with the ODMHSAS to provide mental health, substance abuse, and case management treatment services. Both of these provider types must also contract with the OHCA directly to receive SoonerCare reimbursement.~~

~~(B) **Private facilities.** Private facilities are those facilities that contract directly with the Oklahoma Health Care Authority to provide case management services.~~

~~(3) **Service provider education and experience requirements before July 1, 2001.** For case management services to be compensable by SoonerCare, the case manager performing the service must maintain current case management certification from the Department of Mental Health and Substance Abuse Services. For those case managers who are certified on or before July 1, 2001, the following education and experience requirements apply:~~

~~(A) Associate's degree in a related human service field, OR;~~

~~(B) Two years of college education plus two years or more human service experience, OR;~~

~~(C) Bachelor's degree in a related human service field plus one year or more human service experience, OR;~~

~~(D) Master's degree in a related human service field.~~

~~(4) **Service provider education and experience requirements after July 1, 2001.** The following education and experience requirements apply after July 1, 2001.~~

~~(A) Bachelor's or Master's degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling, OR~~

~~(B) A current license as a registered nurse in Oklahoma; OR~~

~~(C) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis, AND~~

~~(D) Current case management certification from the Department of Mental Health and Substance Abuse Services.~~

~~(5) **Service provider education and experience requirements after July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current behavioral health case manager certification from the ODMHSAS and meet either (A), (B), or (C) below, and (D):~~

~~(A) Certified Behavioral Health Case Manager III B meets the Licensed Behavioral Health Professional status as defined at OAC 317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.~~

~~(B) Certified Behavioral Health Case Manager II B a bachelor's or master's degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes but is not limited to psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-based Case Management Competency Exam, and complete seven hours of ODMHSAS specified CM training.~~

~~(C) Certified Behavioral Health Case Manager I B meets the following requirements:~~

~~(i) completed 60 college credit hours; or~~

~~(ii) high school diploma with 36 total months of experience working with persons who have a mental illness. Documentation of experience must be on file with ODMHSAS; and~~

~~(iii) passes the ODMHSAS web-based Case Management Competency Exam, and completes 14 hours of ODMHSAS specified CM training.~~

~~(D) All certified case managers must fulfill the continuing education requirements as laid out in OAC 450:50-5-4.~~

317:30-5-586. Coverage by category [REVOKED]

~~Payment is made for case management services as set forth in this Section.~~

~~(1) **Adults.** Payment is made for services to adults as follows:~~

~~(A) **Description of case management services.** Services under case management are not comparable in amount, duration and scope. The target group for case management services is the chronically and/or severely mentally ill. Chronically and/or severely mentally ill individuals refer to institutionalized adults or adults at risk of institutionalization. All case management services will be subject to medical necessity criteria. The criteria will be applied to each individual case by an agent designated by the OHCA or its designated agent.~~

~~(i) Behavioral health case management services are provided to assist consumers in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides referral, linkage and advocacy on behalf of consumers, to help consumers access appropriate community resources. Case management is designed to assist individuals in accessing services for themselves. The consumer has the right to refuse case management and cannot be restricted from other services because of a refusal of case management services. However, in referring a consumer for medical services, the case manager should be aware that the SoonerCare program is limited in scope. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by the ODMHSAS. In order to be compensable, the service must be performed utilizing the ODMHSAS Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Helping activities are designed to occur primarily in the~~

~~community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member by phone or face-to-face, to identify immediate needs for return to home/community. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month.~~

~~(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.~~

~~(iii) In order to ensure that case management services are not duplicated by other staff, case management activities will be provided in accordance with a comprehensive individualized treatment/service plan.~~

~~(iv) The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health case manager, and a licensed behavioral health professional as defined at OAC 317:30-5-240.~~

~~(v) SoonerCare reimbursable behavioral health case management services include the following:~~

~~(I) Gathering necessary psychological, educational, medical, and social information for the purpose of service plan development.~~

~~(II) Face-to-face meetings with the child and/or the parent/guardian/family member for the implementation of activities delineated in the service plan.~~

~~(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the service plan.~~

~~(IV) Supportive activities such as non face-to-face communication with the child and/or parent/guardian/family member or the behavioral health case manager's travel time to and from meetings for the purpose of development or implementation of the service plan.~~

~~(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the service plan.~~

~~(vi) Reimbursable case management does not include:~~

~~(I) physically escorting or transporting a member to scheduled appointments or staying with the member during an appointment; or~~

~~(II) monitoring financial goals; or~~

~~(III) providing specific services such as shopping or paying bills; or~~

~~(IV) delivering bus tickets, food stamps, money, etc.; or~~

~~(V) services to nursing home residents; or~~

~~(VI) counseling or rehabilitative services, psychiatric assessment, or discharge; or~~

~~(VII) filling out forms, applications, etc., on behalf of the member when the member is not present; or~~

~~(VIII) filling out SoonerCare forms, applications, etc., or;~~

~~(IX) services to members residing in ICF/MR facilities.~~

~~(B) **Providers.** Case management services must be provided by a Community Mental Health Center or other qualifying provider agency of case management. Two different provider agencies may not bill case management service(s) for the same member on the same day.~~

~~(2) **Children.** Coverage for children is found in OAC 317:30-5-596.~~

~~(3) **Individuals eligible for Part B of Medicare.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.~~

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES ~~FOR INDIVIDUALS UNDER 21 YEARS OF AGE~~

317:30-5-595. Eligible providers

Services are provided by ~~case management~~ outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.

(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:

(A) ~~On or after July 1, 2004, OHCA will require agencies to have~~ Agencies must hold current accreditation appropriate to outpatient behavioral health ~~case~~

~~management~~ from JCAHO, CARF, COA, or AOA, and maintain the standards of the accreditation at all times.

(B) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.

(C) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals ~~under the age of 21~~ must be community based ~~with a history of serving seriously emotionally disturbed (SED) children and their families~~.

(D) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.

(E) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.

(F) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.

(G) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2. ~~A site is defined as an office, clinic, or other business setting where case management services are routinely performed. When services are rendered at the patient's residence, a school, or an appropriate community based setting, a site is determined according to where the professional staff conduct administrative duties and where the patient's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.~~

(2) **Provider ~~types~~ Qualifications.**

~~(A) **ODMHSAS public and private facilities.** Public ODMHSAS facilities are regionally based Community Mental Health Centers. Private ODMHSAS facilities are providers that have a contract with the ODMHSAS to provide Mental Health, Substance Abuse, and Case Management Treatment Services. Both of these provider types must also contract with the OHCA directly to receive SoonerCare reimbursement.~~

~~(B) **Private facilities.** Private facilities are those facilities that contract directly with the Oklahoma Health Care Authority to provide case management (CM) services.~~

(~~3~~A) **Service provider education and experience requirements if certified before July 1, 2001.** For case management services to be compensable by SoonerCare, the case manager performing the service must maintain current case management certification from the ~~Oklahoma Department of Mental Health and Substance Abuse Services~~ ODMHSAS. For those case managers who are certified on or before July 1, 2001, the following education and experience requirements apply:

(~~A~~ i) ~~Associate's~~ Associate degree in a related human service field, OR;

(~~B~~ ii) Two years of college education plus two years or more human service experience, OR;

(~~C~~ iii) ~~Bachelor's~~ Bachelors degree in a related human service field plus one year or more human service experience, OR;

(~~D~~ iv) ~~Master's~~ Masters degree in a related human service field.

(~~4~~B) **Service provider education and experience requirements if certified after July 1, 2001 and before July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current ~~children's~~ behavioral health case manager certification from the ODMHSAS and have a:

(~~A~~ i) ~~Bachelor's~~ Bachelors or ~~Master's~~ masters degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling; OR

(~~B~~ ii) A current license as a registered nurse in Oklahoma with experience in behavioral health care; OR

(~~C~~ iii) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug dependencies or addictions as a primary or secondary ~~DSMIV~~ DSM-IV Axis I diagnosis; and

(~~D~~ iv) Current case management certification from the ODMHSAS.

(~~5~~C) **Service provider education and experience requirements if certified after July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current ~~children's~~ behavioral health case manager certification from the ODMHSAS and meet either ~~(A)~~ (i), ~~(B)~~ (ii), or ~~(C)~~ (iii) below, and ~~(D)~~ (iv):

(~~A~~ i) Certified Behavioral Health Case Manager III - meets the Licensed Behavioral Health Professional status as defined at OAC 317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.

(~~B~~ ii) Certified Behavioral Health Case Manager II- a ~~bachelor's~~ bachelors or ~~master's~~ masters degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes ~~but is not limited to~~ psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology,

gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, education and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-based Case Management Competency Exam, and complete seven hours of ODMHSAS specified CM training.(After July 1, 2010: Any bachelors or masters degree earned from a regionally accredited college or university recognized by the USDE).

(~~C~~ iii) Certified Behavioral Health Case Manager I– meets the requirements in either ~~(i)~~ (I) or ~~(ii)~~ (II), and ~~(iii)~~ (III):

(~~i~~ I) completed 60 college credit hours; or

(~~ii~~ II) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(~~iii~~ III) passes the ODMHSAS web-based Case Management Competency Exam, and completes 14 hours of ODMHSAS specified CM training.

(D) **Wraparound Facilitator Case Manager** - meets the qualifications for CM II or CM III and has the following:

(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and

(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS;

(E) **Intensive Case Manager** - meets the provider qualifications of a Case Manager II or III and has the following:

(i) A minimum of 2 years Behavioral Health Case Management experience, crisis intervention experience, and

(ii) must have attended the ODMHSAS 6 hours Intensive case management training.

(~~D~~ F) All certified case managers must fulfill the continuing education requirements as outlined under OAC 450:50-5-4.

317:30-5-596. Coverage by category

Payment is made for behavioral health case management services as set forth in this Section.

~~(1) **Adults.** Coverage for adults is found in OAC 317:30-5-586.~~

(~~2~~ 1) ~~**Children.**~~ Payment is made for services ~~to persons under age 21~~ rendered to SoonerCare member's as follows:

(A) **Description of behavioral health case management services.** Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the ~~child~~ member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ~~the Oklahoma Department of Mental Health and Substance Abuse Services~~ ODMHSAS. In order to be compensable, the service must be performed utilizing the ~~ODMHSAS~~ Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the ~~child~~ member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For ~~children~~ member's discharging from an

~~out of home placement~~ higher level of care than outpatient, ~~the out of home agency/placement~~ the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and ~~services~~ post discharge services. The case manager will make contact with the ~~child~~ member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a ~~face-to-face~~ follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within ~~2~~ two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the ~~child~~ member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the ~~child~~ member (and family's, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. ~~Behavioral health case management individual plan of care development is compensable if the time is spent communicating with the child, parent/guardian/family member or provider of other services.~~ The individual plan of care must be developed with participation by, as well as, reviewed and signed by the ~~child~~ member (~~only if over 16 years of age~~), the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d).

(v) SoonerCare reimbursable behavioral health case management services include the following:

(I) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(II) Face-to-face meetings with the ~~child~~ member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(IV) Supportive activities such as non face-to-face communication with the ~~child~~ member and/or parent/guardian/family member or the behavioral health case manager's travel time to and from meetings for the purpose of development or implementation of the individual plan of care.

(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(VI) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(VII) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(VIII) Transitioning from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. These time requirements are to distinguish case management services that are not within

the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

(B) Levels of Case Management

(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individuals strengths and meet needs in order to achieve stability in the community.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM). Intensive Case Management is targeted to adults with serious and persistent mental illness (including member's in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including member's in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To ensure that these intense needs are met, case manager caseloads are limited to 25. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience,crisis intervention experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required.

(~~vi~~C) **Excluded Services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

(~~I~~i) Physically escorting or transporting a ~~child~~ member or family to scheduled appointments or staying with the ~~child~~ member during an appointment; or

(~~II~~ii) Managing finances; or

(~~III~~iii) Providing specific services such as shopping or paying bills; or

(~~IV~~iv) Delivering bus tickets, food stamps, money, etc.; or

(~~V~~v) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or

(~~VI~~vi) Filling out forms, applications, etc., on behalf of the ~~child~~ member when the ~~child~~ member is not present; or

(~~VII~~vii) Filling out SoonerCare forms, applications, etc., ~~or~~;

(~~VIII~~viii) Mentoring or tutoring; or

(~~IX~~ ix) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies.

(~~B~~D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:

(i) Children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;

(ii) ~~Children~~ Members receiving ~~services in~~ Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;

(iii) Residents of ICF/MR and nursing facilities unless transitioning into the community; ~~and~~

(iv) ~~Children~~ Members receiving services under a Home and Community Based ~~Waiver~~ services (HCBS) waiver program.

~~(C) **Restriction.** Two different provider agencies may not bill case management services for the member on the same day.~~

(~~3~~E) ~~**Individuals eligible for Part B of Medicare.**~~ Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

317:30-5-596.1. Prior authorization

(a) Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA, or its designated agent.

(b) SoonerCare members who are eligible for services will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be approved to receive case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services unless transitioning from a higher level of care than outpatient. A SoonerCare member may be approved for a time frame of one to ~~six~~ twelve months. The OHCA, or its designated agent will review the initial request in accordance with the guidelines for prior authorization in the Outpatient Behavioral Health Service Provider Manual. An initial request for case management services requires the provider to submit specific documentation to OHCA, or its designated agent. A fully developed individual plan of service is not required at the time of initial request. The provider will be given a time frame to develop the individual plan of service while working with the child and his/her family and corresponding units of service will be approved prior to the completion of the service plan. ~~The provider will be required to engage with the child/family within 72 hours of discharge from an inpatient psychiatric~~

~~hospital and/or within 72 hours of receiving the request for services from the family or other community resource. The expectation is for the behavioral health case manager to immediately engage with the child/family to prevent hospital readmission or other out of home placement, and refer to needed community resources.~~ Prior authorization requests will be reviewed by licensed behavioral health professionals as defined at OAC 317:30-5-240.

~~(c) In the event that a member disagrees with the decision by OHCA's contractor, it receives an evidentiary hearing under OAC 317:2-1-2(a). The member's request for such an appeal must commence within 20 calendar days of the initial decision.~~

~~(d) Providers seeking prior authorization will follow OHCA's or its designated agent's prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.~~

317:30-5-596.2. Direct and Indirect Case Management services [REVOKED]

~~Case management services are provided using one of two categories of service.~~

~~(1) **Direct case management services.** For Direct case management services the behavioral health case manager performs face to face interactions with the child and/or the child's parent/guardian/family member or service providers necessary for the implementation of activities delineated in the service plan. Service plan development, when performed face to face, is considered direct behavioral health case management.~~

~~(2) **Indirect behavioral health case management.** For Indirect case management services the behavioral health case manager performs non face to face services related to the child's case, excluding those activities cited as non Medicaid compensable in OAC 317:30-5-596(2)(vi). Examples of indirect behavioral health case management are phone calls, monitoring of client progress and the case manager's travel time to or from activities necessary for the implementation of the service plan. Other indirect services may be communication through letters, memorandums or e-mail to treatment or other service providers necessary for the implementation of activities delineated in the service plan. Electronic communication documentation must be encrypted and meet HIPAA guidelines.~~

PART 97. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 AT RISK OF OR IN THE TEMPORARY CUSTODY OR SUPERVISION OF OFFICE OF JUVENILE AFFAIRS

317:30-5-972. Reimbursement

~~(a) Reimbursement for OJATCM services is a unit rate based on the monthly cost per case for documented OJATCM services. A unit of service is defined as one calendar month of case management, provided that a minimum of one contact which meets the description of a case management activity with or on behalf of the recipient has been documented during the month claimed. Payment is made on the basis of claims submitted for payment. The provider bills at the monthly unit rate for documented Medicaid OJATCM services provided to each Medicaid eligible recipient during the calendar month.~~

~~(b) Only one unit of OJATCM services may be billed for each Medicaid eligible recipient per month. OJATCM services may not be billed for any recipient already receiving case management services as part of a Home and Community Based waiver.~~ Office of Juvenile Affairs Targeted Case Management (OJATCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Title XIX State Plan.

PART 99. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 IN EMERGENCY, TEMPORARY OR PERMANENT CUSTODY OR SUPERVISION OF THE DEPARTMENT OF HUMAN SERVICES

317:30-5-992. Reimbursement

~~(a) Reimbursement for CWTCM services is a unit rate based on the monthly cost per case for documented CWTCM services. A unit of service is defined as one calendar month of case management, provided that a minimum of one contact which meets the description of a case management activity with or on behalf of the recipient has been documented during the month claimed. Payment is made on the basis of claims submitted for payment. The provider bills at the monthly unit rate for documented unit of Medicaid CWTCM services provided to each Medicaid eligible recipient during the calendar month.~~

~~(b) Only one unit of CWTCM services may be billed for each Medicaid eligible recipient per month. CWTCM services may not be billed for any recipient already receiving case management services as part of a Home and Community Based waiver.~~ Child Welfare Targeted Case Management (CWTCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Title XIX State Plan.

[OAR Docket #10-790; filed 5-7-10]

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

[OAR Docket #10-791]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
317:30-5-764. [AMENDED]
Part 95. Agency Personal Care Services
317:30-5-950. [AMENDED]
(Reference APA WF # 09-65A)

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The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.180

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N/A
ANALYSIS:
Rules are revised to require the use of the new Interactive Voice Response Authentication (IVRA) system to document time and attendance for all Personal Care and certain in-home ADvantage services provided to SoonerCare members. In-home services are necessarily provided in the individual homes of persons with physical and cognitive disabilities. The verification of service delivery is typically a paper time sheet signed by the member receiving services with a high potential for errors. Additionally, a paper based time and attendance system which requires transcription of time units from paper to computer is both inefficient and affords many opportunities for inadvertent errors.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

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~~ State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

(1) The rate for NF Respite is set equivalent to the rate for routine level of care 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 ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(A) The ~~individual~~ Individual Budget Allocation (IBA) ~~expenditure~~ Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The PSA and APSA service unit rates are calculated by the ~~AA~~ OKDHS/ASD during the CD-PASS service eligibility determination process. The ~~AA~~ OKDHS/ASD sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate

to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. If the 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 member need. The ~~AA~~ OKDHS/ASD, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(7) Three per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member ADL/IADL and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 of the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 of the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 of the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider. ADvantage payment is not made for 24-hour skilled care in an Assisted Living Center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day care or environmental modifications to a member while receiving Assisted Living Services since these services are integral to and inherent in the provision of Assisted Living Service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage Assisted Living. Separate payment is not made for ADvantage respite to a member while receiving Assisted Living Services since by definition Assisted Living Services assume the responsibility for 24-hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage Assisted Living Services provider is allowed to charge a maximum for room and board that is no more than 90% of the SSI Federal Benefit Rate. If in accordance with OAC 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

(b) The ~~AA~~ OKDHS/ASD 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 provisions will be turned over to SURS for follow-up investigation.~~ Service time for Personal Care, Case Management, Case Management services for Transitioning, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance is documented solely through the use of the Interactive Voice Response Authentication (IVRA) system when services are provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

(d) 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 provisions will be turned over to SURS for follow-up investigation.

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-950. Eligible providers

Payment is made only to agencies that have been certified as personal care providers by the Oklahoma State Department of Health and are certified by the ~~ADvantage Program Administrative Agent~~ ADvantage Administration ~~(~~AA~~)~~ as meeting applicable federal, state and local laws, rules and regulations. In order to be eligible for payment, the personal care agency must have an approved provider agreement on file with the ~~Mecicaid agency~~ OHCA, in accordance with OAC 317:30-3-2. Service time of Personal Care is documented solely through

the Interactive Voice Response Authentication (IVRA) system when services are provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

[OAR Docket #10-791; filed 5-7-10]

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

[OAR Docket #10-793]

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N/A
ANALYSIS:
Children's inpatient psychiatric treatment rules are revised to add Licensed Alcohol and Drug Counselor (LADC) as a Licensed Behavioral Health Professional (LBHP). Children's inpatient services are reimbursed by DRG or per diem; this modification would expand the type of licensure staff can hold in order to provide the services required under these payments.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.33. Individual plan of care for children

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

(1) **"Licensed Behavioral Health Professional ~~(LBPH)~~ (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to a PRTF and is the document that directs the care and treatment of that member. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual

member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community;

(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF and every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for patients under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. In those instances where it is necessary to fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or Xeroxed signatures are not allowed for any parent or member of the treatment team.

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

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Inpatient behavioral health rules are revised to more clearly define reimbursement methods for ancillary and professional services provided in inpatient psychiatric hospitals.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALITIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-96.3. Methods of payment

(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services ~~rendered on or after October 1, 2005,~~ will be reimbursed using one of the following methodologies:

(1) Diagnosis Related Group (DRG);

(2) cost based; or

(3) a predetermined per diem payment.

(b) **Acute Level of Care.**

(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. ~~[See OAC 317:30-5-41(1)(B)]~~ [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(2) Freestanding Psychiatric Hospitals ~~and Psychiatric Units within Rehabilitation Hospitals~~. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(c) **Psychiatric Residential Treatment Facility (PRTF).**

(1) **Instate Levels of Service.**

(A) Community-Based, extended. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional services.

(B) Community-Based, transitional. A pre-determined per diem payment will be made for routine services. All other services are separately billable.

(C) Freestanding, Private. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services.

(D) Freestanding, Public. Facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(E) Provider based. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services.

(2) **Out-of-state services.**

(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state PRTFs.

(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units and/or subacute services. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges.

[OAR Docket #10-789; filed 5-7-10]

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

[OAR Docket #10-786]

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317:35-1-2. [AMENDED]
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-6. [AMENDED]
317:35-5-6.1. [AMENDED]
Subchapter 6. SoonerCare ~~Health Benefits~~ for ~~Categorically Needy~~ Pregnant Women and Families with Children
Part 3. Application Procedures
317:35-6-15. [AMENDED]
Part 5. Determination of Eligibility for SoonerCare ~~Health Benefits~~ for Pregnant Women and Families with Children
317:35-6-38. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-6-62. [AMENDED]
317:35-6-63. [AMENDED]
317:35-6-64. [AMENDED]
317:35-6-64.1. [AMENDED]
Subchapter 7. Medical Services
Part 3. Application Procedures
317:35-7-15. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-7-60.1. [AMENDED]
317:35-7-63. [AMENDED]
317:35-7-64. [AMENDED]
317:35-7-65. [AMENDED]
Subchapter 22. Pregnancy Related Benefits Covered Under Title XXI
317:35-22-9. [AMENDED]
317:35-22-11. [AMENDED]
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Subchapter 10. Medical Aid to Families with Dependent Children
Part 5. Income
317:35-10-26. [AMENDED]
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Subchapter 10. Medical Aid to Families with Dependent Children
Part 5. Income
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Superseded rules:
Subchapter 1. General Provisions
317:35-1-2. [AMENDED]
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-6. [AMENDED]
317:35-5-6.1. [AMENDED]
Subchapter 6. SoonerCare ~~Health Benefits~~ for ~~Categorically Needy~~ Pregnant Women and Families with Children
Part 3. Application Procedures
317:35-6-15. [AMENDED]
Part 5. Determination of Eligibility for Sooner ~~Health Benefits~~ for Pregnant Women and Families with Children
317:35-6-38. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-6-62. [AMENDED]
317:35-6-63. [AMENDED]
317:35-6-64. [AMENDED]
317:35-6-64.1. [AMENDED]
Subchapter 7. Medical Services
Part 3. Application Procedures
317:35-7-15. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-7-60.1. [AMENDED]
317:35-7-63. [AMENDED]
317:35-7-64. [AMENDED]
317:35-7-65. [AMENDED]
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In 2007, the OHCA received a Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a web based online application and eligibility determination system in order to improve the ease and efficiency of enrollment. Originally known as No Wrong Door, the process allows potential members to apply for SoonerCare electronically. Effective in March 2010, the OHCA will assume responsibility for determining eligibility for certain groups of individuals under SoonerCare. The process will be phased in over a period of time, starting with the easiest groups who have no asset test and use income declaration: families with children, pregnant women, and individuals requesting only family planning services. As OHCA will now be determining eligibility for some of our population, parts of our eligibility rules and grievance rules are revised to incorporate these new responsibilities. In addition, eligibility for these three groups will no longer be retroactive to the first day of the month of application but will be effective the date of application or later.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

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

"Acute Care Hospital" means an institution that meets the requirements of 42 CFR, Section 440.10 and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) meets the requirements for participation in Medicare as a hospital.

"~~Administrative agent~~ ADvantage Administration (AA)" means ~~the Long Term Care Authority who is under contract with~~ the Oklahoma Department of Human Services (OKDHS) ~~to perform~~ which performs certain administrative functions related to the ADvantage Waiver.

"AFDC" means Aid to Families with Dependent Children.

"Aged" means an individual whose age is established as 65 years or older.

"**Agency partner**" means an agency or organization contracted with the OHCA that will assist those applying for services.

"**Aid to Families with Dependent Children**" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all ~~Medicaid clients~~ SoonerCare members related to AFDC.

"**Area nurse**" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"**Area nurse designee**" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"**Authority**" means the Oklahoma Health Care Authority (OHCA).

"**Blind**" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"**Board**" means the Oklahoma Health Care Authority Board.

"**Buy-in**" means the procedure whereby the ~~Authority~~ OHCA pays the ~~client's~~ member's Medicare premium.

(A) "**Part A Buy-in**" means the procedure whereby the ~~Authority~~ OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) "**Part B Buy-in**" means the procedure whereby the ~~Authority~~ OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"**Caretaker relative**" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"**Case management**" means the activities performed for ~~client's~~ members to assist them in accessing services, advocacy and problem solving related to service delivery.

"**Categorically needy**" means that income and when applicable, resources are within the standards for the category to which the ~~client~~ individual is related.

"**Categorically related" or "related**" means the individual is:

(A) aged, blind, or disabled;

(B) pregnant;

(C) an adult individual who has a minor child under the age of 18~~ and who is deprived of parental support due to absence, death, incapacity, unemployment~~; or

(D) a child under 19 years of age.

"**Certification period**" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"**County**" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

~~"CSED" means the Oklahoma Department of Human Services' Child Support Enforcement Division.~~

"**Custody**" means the custodial status, as reported by the Oklahoma Department of Human Services.

"**Deductible/Coinsurance**" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for in-patient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (~~Supplemental~~ Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

"**Disabled**" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

"**Disabled child**" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"**Estate**" means all real and personal property and other assets included in the ~~recipient's~~ member's estate as defined in Title 58 of the Oklahoma Statutes.

"Gatekeeping" means the performance of a comprehensive assessment by the ~~LTC~~ OKDHS nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Local office" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

~~**"LTC nurse"** means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The LTC nurse also develops care plans and service plans for Personal Care services based on the UCAT.~~

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of ~~two~~ four separate programs. Part A is Hospital Insurance, ~~(HI) and~~ Part B is ~~Supplemental~~ Medical Insurance, ~~(SMI)~~ Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare ~~(HI)~~"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been receiving disability benefits under these programs for at least 24 months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for ~~Medicaid~~ SoonerCare benefits as categorically needy. They must however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare ~~(SMI)~~"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under ~~Authority~~ OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of 18.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for the mentally retarded or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the Oklahoma Department of Human Services' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the Oklahoma Health Care Authority that assists with the eligibility determination process.

"OKDHS" means the Oklahoma Department of Human Services.

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Recipient lock-in" means when a ~~recipient~~ member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a ~~Medicaid recipient~~ SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a 12-month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for ~~Medicaid~~ SoonerCare if residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays are expected to last not less than 60 days.

"Worker" means the OHCA or OKDHS worker responsible for ~~Medicaid~~ assisting in eligibility determinations.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-6. Determining categorical relationship to pregnancy-related services

Categorical relationship to pregnancy-related services can be established by determining through medical evidence that the individual is currently or has been pregnant. Pregnancy must be verified by providing medical proof of pregnancy within 10 days of application submission. ~~Form MS-MA-5~~ OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. ~~Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is or has been pregnant.~~ If proof of pregnancy is not provided within 10 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the ten day period. The expected date of delivery must be established either by information from the applicant's physician or certified nurse midwife or the ~~client's~~ member's statement.

317:35-5-6.1. Determining categorical relationship for pregnancy related services covered under Title XXI

Categorical relationship for pregnancy related benefits covered under Title XXI are determined in accordance with OAC 317:35-22-1 and through medical evidence that the individual is currently or has recently been pregnant and may qualify for pregnancy related services. Pregnancy must be verified by providing medical proof of pregnancy within 10 days of application submission. ~~Form MS-MA-5~~ OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. ~~Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is or has been pregnant.~~ If proof of pregnancy is not provided within 10 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the ten day period. The applicant must be residing in the State of Oklahoma with the intent to remain at the time the medical service is received. The expected date of delivery must be established either by information from the applicant's physician or other qualified practitioner.

SUBCHAPTER 6. SOONERCARE ~~HEALTH BENEFITS~~ FOR ~~CATEGORICALLY NEEDY~~ PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 3. APPLICATION PROCEDURES

317:35-6-15. Application for SoonerCare ~~Health Benefits~~ for Pregnant Women and Families with Children; forms

(a) **Application.** An application for categorically needy pregnant women and families with children consists of the ~~Health Benefits Application~~ SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for ~~Health Benefits for Pregnant Women and Families with Children~~ SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, ~~or~~ in the county OKDHS office, or online. A face to face interview is not required. Applications ~~may be~~ are mailed ~~or faxed~~ to the ~~local county OKDHS office~~ OHCA Eligibility Unit. ~~If faxed, it is not necessary to send the original application.~~ When an individual indicates a need for ~~health benefits~~ SoonerCare, the physician or facility may forward an application to the ~~OKDHS county office of the patient's residence~~ OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) ~~Form~~ OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the ~~Health Benefits~~ SoonerCare Application form or ~~Form~~ OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If ~~Form~~ OKDHS form 08MA005E is received and ~~an~~ a SoonerCare application cannot be completed, receipt of ~~Form~~ OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The ~~member~~ applicant and provider are notified by computer-generated notice.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or ~~Form~~ OKDHS form 08MA005E is stamped with the date the application was received into the ~~county office~~ OHCA Eligibility Unit. ~~When an application is faxed, the application date is the date the fax is received.~~ When a request for ~~Health Benefits~~ SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application ~~to be shown on the computer form~~ to be used. When ~~Form~~

OKDHS form 08MA005E is received in the ~~county office~~ OHCA Eligibility Unit prior to the completion of the application form, the date that ~~Form~~ OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the ~~OKDHS county office~~ OHCA Eligibility Unit for ~~Health Benefits~~ SoonerCare eligibility determination. Under this circumstance, the application date is the date the ~~member~~ applicant signed the application form for the provider.

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE ~~HEALTH BENEFITS~~ FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-38. Presumptive eligibility for pregnant women

(a) Presumptive Eligibility (PE) is a limited period of ~~Medicaid~~ SoonerCare eligibility for categorically needy pregnant women that is determined by a qualified provider. Its purpose is to encourage pregnant women to receive adequate prenatal care in the earlier months of their pregnancy, and to ensure qualified providers of payment for the prenatal care. The PE period precedes the ~~Health Benefits~~ SoonerCare eligibility determination ~~made by the county office,~~ and begins on the date a qualified provider makes a determination of presumptive eligibility. The basis for the determination is preliminary information that the net family income of the pregnant woman does not exceed the standards on the OHCA website or the ~~DHS Appendix C-1~~ OKDHS form 08AX001E, Schedule I, which are 185% of the Federal Poverty Level.

(b) Pregnant women are excluded from a resource test. When a qualified provider has made this determination, the provider is required to notify the county office in the ~~pregnant woman's residence county~~ OHCA Eligibility Unit within five working days after the date of PE determination. The ~~county office~~ OHCA Eligibility Unit does not make PE determinations. When a PE determination is received, the worker determines ~~Health Benefits~~ SoonerCare eligibility using normal procedures.

(1) **Qualified providers.** The determination that a provider is qualified to make a PE determination is made by the OHCA. A listing of approved qualified providers is found ~~in DHS Appendix M-10, Certified Medicaid Presumptive Eligibility Providers which is available only on line on the computer terminal~~ on the OHCA website. The ~~county office~~ OHCA Eligibility Unit must be sure a PE determination is made only by a qualified provider ~~who is included in this Appendix~~.

(2) **Application and eligibility determination process for presumptive eligibility.** The ~~county offices supply~~ OHCA Eligibility Unit supplies the qualified providers with the necessary forms and instructions to complete and correctly determine PE for pregnant women.

(A) The forms include the following:

(i) The ~~Health Benefits~~ SoonerCare Application. This form must be completed at the PE determination and serves to gather information to complete PE determination and also to use for ~~Health Benefits~~ SoonerCare eligibility determination ~~by the worker~~;

(ii) OHCA Form MA-PE-1, Presumptive Eligibility Budget Sheet, which is completed by the qualified provider to verify pregnancy and provide income screening necessary to determine PE. Instructions for completing the form and eligibility rules are included on the back of the form; and

(iii) OHCA Form MA-PE-2, Notice to Pregnant Women Regarding Presumptive Eligibility for ~~Medicaid~~ SoonerCare, which is completed and given to the pregnant woman by the qualified provider. It informs her whether she has been determined to be presumptively eligible or ineligible by the qualified provider. It also contains information regarding the application process as well as a detailed list of what ~~the DHS county office needs~~ is needed to complete the ~~Health Benefits~~ SoonerCare application.

(B) After determining the pregnancy of the individual, the qualified provider determines financial eligibility. OHCA Form MA-PE-1 is completed to document the pregnancy and the financial eligibility. If the qualified provider determines the individual meets PE requirements, OHCA Form MA-PE-2 is completed and given to the individual. The originals of the ~~Health Benefits~~ SoonerCare Application form and OHCA Form MA-PE-1 are sent to the ~~DHS county office of the woman's residence~~ OHCA Eligibility Unit. They must be received within five working days after the date of the PE determination.

(C) If the individual is determined by the qualified provider to not meet PE requirements, the qualified provider completes OHCA Form MA-PE-2 and gives it to the individual. The qualified provider also advises the individual she may be eligible for ~~Medicaid~~ SoonerCare and refers her to the on line application or the OKDHS county office for ~~Medicaid~~ SoonerCare eligibility determination.

(D) A PE determination may be made at any time during a pregnancy, even if there is an application pending ~~at the county office~~. Only one PE period will be granted during a pregnancy.

(E) Only a pregnant woman may be determined as PE. No other household member may be certified as presumptively eligible.

(3) **Household definition.** For purposes of this Section, the household is defined as the pregnant woman, her spouse or male acting in the role of the spouse, and her minor dependent children. The unborn child(ren) is also included as a member(s) of the household. If the pregnant woman is under age 18 and lives with her parent(s), the parent(s) is considered a household member(s). Other minor siblings may be included as household members.

(4) **Income computation.** The PE determination of the pregnant woman requires the provider to compute the total monthly income of the household as shown on the ~~Health Benefits~~ SoonerCare Application. The total monthly income includes the earned and unearned income of all household members. If the pregnant woman is a minor (under age 18) and lives with her parents, her parents' income must be included, regardless of the minor pregnant woman's marital status. The income included in the PE determination is the total income received in the month that PE is determined by the qualified provider. The household's total net income must be equal to or less than the ~~applicable maintenance standard~~ standards on the OHCA website or the ~~DHS Appendix C-1~~ OKDHS Form 08AX001E, Schedule I, which are 185% of the Federal Poverty Level.

(A) Countable earned income is the gross earnings of each household member minus the AFDC work related expenses and paid dependent care expenses not to exceed the AFDC dependent care limits (see OAC 317:35-10). Countable unearned income is the total unearned income of all household members. The AFDC rule on unearned income exclusions is followed.

(B) The total countable net earned income plus the total countable unearned income is the total countable net income. This total and the household size is compared to the standards on OHCA Form MA-PE-1 to determine financial eligibility.

(5) **Presumptive eligibility period.** Presumptive eligibility begins on the date a qualified provider determines the total countable monthly net income of a pregnant woman's household does not exceed the eligibility standard on the OHCA website ~~DHS Appendix C-1~~ or OKDHS Form 08AX001E, Schedule I. Presumptive eligibility ends with (and includes) the earlier of:

(A) The day an eligibility or ineligibility determination is made ~~by the worker~~; or

(B) The 45th day after the date on which the qualified provider made the PE determination (the 45 day count begins on the day following the eligibility determination date).

(6) **Approval of presumptive eligibility.** When the ~~county~~ OHCA Eligibility Unit receives timely a completed PE certification, a case number, if needed, is assigned. The PE certification is processed within five working days. The ~~client~~ applicant ~~and the qualified provider are~~ is notified of the PE determination by computer generated notice. The notice also advises that the PE period expires 45 days from the date of the qualified provider's approval. The case is automatically closed at the end of the 45 day period if a ~~Health Benefits~~ decision has not been made ~~by the worker~~ on the SoonerCare application. ~~Although not reflected on the computer, the Health Benefits case remains pending until appropriate action is taken by the worker.~~

(7) **Incomplete/incorrect presumptive eligibility forms.** Upon receipt of the ~~Health Benefits~~ SoonerCare Application and OHCA Form ~~MA-PE-1~~ MA-PE-1 from the qualified provider, the ~~county office~~ OHCA Eligibility Unit immediately screens them for completeness and correct determination.

(A) The ~~Health Benefits~~ SoonerCare Application for PE is considered incomplete if it is not filled out in its entirety, properly signed and dated. OHCA Form MA-PE-1 is considered incomplete if any response is omitted or if the form is not properly signed and dated.

(B) The presumptive eligibility determination is considered to be incorrect if the provider submitting the certification ~~is not shown on Appendix M-10, Certified Medicaid Presumptive Eligibility Providers, as~~ has not been determined to be a qualified provider by the OHCA. The presumptive eligibility decision is also incorrect if the income computed by the qualified provider exceeds the allowable standard.

(C) When it is determined the PE certification is incomplete or incorrect, the original OHCA Form MA-PE-1 and a copy of the ~~Health Benefits~~ SoonerCare application, are returned to the qualified provider. The worker proceeds with the ~~Health Benefits~~ SoonerCare eligibility determination. To maintain the original PE certification period, the qualified provider must correct and/or complete the forms and return them to the ~~county office~~ OHCA Eligibility Unit within the original five working days. If this requirement is not met, an amended PE determination and PE determination date must be completed by the provider.

(8) **Presumptive eligibility forms not received within five working days.** A qualified provider is required to provide the PE determination to the ~~DHS county office of the pregnant woman's residence~~ OHCA Eligibility Unit within five working days after the date of the PE determination. The forms must be complete and correct as explained in paragraph (7) of this subsection. Forms received on the sixth day (or later) after the PE determination date are returned to the qualified provider with a request for an amended PE determination and PE determination date.

(9) **Erroneous payments and appeal rights.** When an individual is certified as presumptively eligible and a determination is made later that the individual is not eligible for ~~Health Benefits~~ SoonerCare, the PE period ends with the effective date of the ~~Health Benefit~~ SoonerCare application denial. In this instance, the effective date of denial is the day following the date the ineligibility decision is made.

(A) If the ineligibility is not due to a misrepresentation by the ~~client~~ applicant, any payments made are not considered to be erroneous. If the ineligibility is due to the ~~client~~ applicant withholding or misrepresenting information, any payments made are considered to be erroneous and a recipient overpayment is submitted to ~~DHS~~ OKDHS State Office, FSS Overpayment Section.

(B) The ~~client~~ applicant cannot appeal a PE determination made by a qualified provider or the expiration of the PE period (45 days).

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-62. Notification of eligibility

When eligibility for SoonerCare ~~Health Benefits~~ is established, the ~~county office updates the computer form and the~~ appropriate notice is computer generated to the ~~client and provider~~ applicant. When the computer file is updated for changes, notices are generated only if there is a change in the ~~client's financial responsibility~~ eligibility of any household member.

317:35-6-63. Denials

If the denial of ~~Health Benefits~~ SoonerCare is for ~~an~~ the entire ~~family case~~ household, ~~the computer input form is updated and~~ the appropriate notice is computer generated to the ~~client and provider~~ applicant. If an individual(s) is being denied but other family members are eligible, the ~~county provides the~~ denied individual(s) is provided with a notice ~~using the Notification of Eligibility Status for Medical Assistance form~~.

317:35-6-64. Closures

~~Health benefit~~ SoonerCare cases are closed ~~by the county~~ at any time during the certification period that the case becomes ineligible. A computer-generated notice is sent to the ~~client~~ head of the household ~~and the provider~~.

317:35-6-64.1. Transitional Medical Assistance (TMA)

(a) **Conditions for TMA.**

(1) **Transitional Medical Assistance.** Health benefits are continued when the benefit group loses eligibility due to new or increased earnings of the parent(s)/caretaker relative or the receipt of child or spousal support. The health benefit coverage is of the same amount, duration, and scope as if the benefit group continued receiving ~~health benefits~~ SoonerCare. Eligibility for TMA begins with the effective date of case closure or the effective date of closure had the income been reported timely. An individual is included for TMA only if that individual was eligible for ~~Medicaid~~ SoonerCare and included in the benefit group at the time of the closure. To be eligible for TMA the benefit group must meet all of the requirements listed in (A) - (C) of this paragraph.

(A) At least one member of the benefit group was included in at least three of the six months immediately preceding the month of ineligibility.

(B) The health benefit cannot have been received fraudulently in any of the six months immediately preceding the month of ineligibility.

(C) The benefit group must have included a dependent child who met the age and relationship requirements for ~~Medicaid~~ SoonerCare and whose needs were included in the benefit group at the time of closure, unless the only eligible child is a Supplemental Security Income (SSI) recipient.

(2) **Closure due to child support or spousal support.** Health benefits are continued if the case closure is due to the receipt of new or increased child support or payments for spousal support in the form of alimony. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The health benefits are continued for four months.

(3) **Closure due to new or increased earnings of parent(s) or caretaker relative.** Health benefits are continued if the closure is due to the new or increased earnings of the parent(s) or caretaker relative. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The parent(s) or caretaker relative is required to cooperate with ~~Child Support Enforcement Division~~ OKDHS Oklahoma Child Support Services during the period of time the family is receiving TMA.

(4) **Eligibility period.** Health benefits may be continued for a period up to 12 months if the reason for closure is new or increased earnings of the parent(s) or caretaker relative. This period is divided into two six-month periods with eligibility requirements and procedures for each period.

(A) **Initial six-month period.**

(i) The benefit group is eligible for an initial six-month period of TMA without regard to income or resources if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same; and

(III) the benefit group remains in the state.

(ii) An individual benefit group family member remains eligible for the initial six-month period of TMA unless the individual:

(I) moves out of the state,

(II) dies,

(III) becomes an inmate of a public institution,

(IV) leaves the household,

(V) does not cooperate, without good cause, with the ~~Child Support Enforcement Division~~ OKDHS Oklahoma Child Support Services or third party liability requirements.

(B) **Additional Six-month period.**

(i) Health benefits are continued for the additional six-month period if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same;

(III) the benefit group remains in the state;

(IV) the benefit group was eligible for and received TMA for each month of the initial six-month period;

(V) the benefit group has complied with reporting requirements in subsection (g) of this Section;

(VI) the benefit group has average monthly earned income (less child care costs that are necessary for the employment of the parent or caretaker relative) that does not exceed the 185% of the Federal Poverty Level (see OKDHS Appendix C-1, Schedule I.A); and

(VII) the parent(s) or caretaker relative had earnings in each month of the required three-month reporting period described in (g)(2) of this Section, unless the lack of earnings was due to an involuntary loss of employment, illness, or other good cause.

(ii) An individual benefit group family member remains eligible for the additional six-month period unless the individual meets any of the items listed in (4)(A)(ii) of this paragraph.

(b) **Income and resource eligibility.**

(1) The unearned income and resources of the benefit group are disregarded in determining eligibility for TMA. There is no earned income test for the initial six-month period.

(2) Health benefits are continued for the additional six-month period if the benefit group's countable earnings less child care costs that are necessary for the employment of the parent(s) or caretaker relative are below 185% of the Federal Poverty Level (see the standards on the OHCA website or the OKDHS ~~Appendix C-1~~ Form 08AX001E, Schedule I.A) and the benefit group meets the requirements listed in (a)(4)(B).

(A) The earnings of all benefit group members are used in determining the earned income test. The only exception is that earnings of full time students included in the benefit group are disregarded.

(B) Income is determined by averaging the benefit group's gross monthly earnings (except full time student earnings) for the required three-month reporting period.

(C) A deduction from the benefit group's earned income is allowed for the cost of approved child care necessary for the employment of the parent(S) or caretaker relative. The child care deduction is averaged for the same three-month reporting period. There is no maximum amount for this deduction.

(D) All individuals whose earnings are considered are included in the benefit group. The family size remains the same during both reporting periods.

(c) **Eligible child.** When the ~~regular health~~ SoonerCare benefit is closed and TMA begins, the benefit group must include an eligible child whose needs were included in the ~~health~~ SoonerCare benefit at the time of closure, unless the only eligible child is a SSI recipient. After the TMA begins, the benefit group must continue to include an eligible child. Age is the only requirement an eligible child must meet.

(d) **Additional members.** After the TMA begins, family members who move into the home cannot be added to the TMA coverage. This includes siblings and a natural or adoptive parent(s) or caretaker relative. If the additional member is in need of health benefits, an application for services under the ~~regular Medicaid~~ SoonerCare program is completed. If a benefit group member included in TMA leaves the home and then returns, that member may be added back to TMA coverage if all conditions of eligibility are met.

(e) **Third party liability.** The benefit group's eligibility for TMA is not affected by a third party liability. However, the benefit group is responsible for reporting all insurance coverage and any changes in the coverage. The ~~social services specialist~~ worker must explain the necessity for applying benefits from private insurance to the cost of medical care.

(f) **Notification.**

(1) **Notices.** Notices are sent to the benefit group, both at the onset of and throughout the TMA period. These notices, which are sent at specific times, inform the benefit group of its rights and responsibilities. When ~~a health benefit~~ SoonerCare is closed and the benefit group is eligible for TMA, the computer generated closure notice includes notification of the continuation of health benefits. Another computer generated notice is sent at the same time to advise the benefit group of the reporting requirements and under what circumstances the health benefits may be discontinued. Each notice listed in (A)-(C) of this paragraph includes specific information about what the benefit group must report. The notices serve as the required advance notification in the event benefits are discontinued as a result of the information furnished in response to these notices.

(A) **Notice #1.** Notice #1 is issued in the third month of the initial TMA period. This notice advises the benefit group of the additional six-month period of TMA, the eligibility conditions, reporting requirements, and appeal rights.

(B) **Notice #2.** Notice #2 is issued in the sixth month of the TMA period, but only if the benefit group is eligible for the additional six-month period. This notice advises the benefit group of the eligibility conditions, reporting requirements, and appeal rights.

(C) **Notice #3.** Notice #3 is issued in the ninth month of the TMA period, or the third month of the additional six-month period. This notice advises the benefit group of the eligibility conditions, the reporting requirements, appeal rights, and the expiration of TMA coverage.

(2) **Notices not received.** In some instances the benefit group does not receive all of the notices listed in (1) of this subsection. The notices and report forms are not issued retroactively.

(g) **Reporting.** The benefit group is required to periodically report specific information. The information may be reported by telephone~~, in an office interview,~~ or by letter.

(1) The benefit group must report:

(A) gross earned income of the entire benefit group for the appropriate three-month period;

(B) child care expenses, for the appropriate three-month period, necessary for the continued employment of the parent(s) or caretaker relative;

(C) changes in members of the benefit group;

(D) residency; and

(E) third party liability.

(2) The reporting requirement time frames are explained in this subparagraph.

(A) The information requested in the third month must be received by the 21st day of the fourth month and is used to determine the benefit group's eligibility for the additional six-month period. While this report is due in the fourth month, negative action cannot be taken during the initial period for failure to report. If the benefit group fails to submit the requested information, benefits are automatically suspended effective the seventh month. If action to reinstate is not taken by deadline of the suspension month, the computer automatically closes the case effective the next month.

(B) The information requested in the sixth month must be furnished by the 21st day of the seventh month. The decision to continue benefits into the eighth month is determined by the information reported.

(C) The information requested in the ninth month must be furnished by the 21st day of the tenth month. The decision to continue health benefits into the 11th month is determined by the information reported. When the information is not reported timely, the TMA is automatically suspended by the computer for the appropriate effective date. If the benefit group subsequently reports the necessary information, the ~~social services specialist~~ worker determines eligibility. If all eligibility factors are met during and after the suspension period, the health benefits are reinstated. The effective date of the reinstatement is the same as the effective date of the suspension so the benefit group has continuous medical coverage.

(h) **Termination of TMA.** The TMA coverage is discontinued any time the benefit group fails to meet the eligibility requirements as shown in this Section. If it becomes necessary to discontinue the TMA coverage for the benefit group or any member of the benefit group, the individual(s) must be advised that he or she may be eligible for health benefits under the ~~regular Medicaid~~ SoonerCare program and how to obtain these benefits.

(i) **Receipt of health benefits after TMA ends.** To ensure continued medical coverage a computer generated recertification form is mailed to the benefit group during the third month of TMA for benefits closed due to the receipt of child or spousal support or the 11th month of TMA for benefits closed due to increased earnings. The benefit group must return the form prior to the termination of the TMA benefits. When determined eligible, health benefits continue as ~~health benefits~~ SoonerCare, not TMA. If the benefit group fails to return the recertification form, TMA benefits are terminated.

SUBCHAPTER 7. MEDICAL SERVICES

PART 3. APPLICATION PROCEDURES

317:35-7-15. Application for Medical Services; forms

(a) **Application.** An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. A ~~categorically needy~~ individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant, have children or are applying for family planning services only. A face to face interview is not required. SoonerCare applications for women who are pregnant, families with children and for family planning services only are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or 08MA005E for individuals who are pregnant, have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) ~~Form~~ OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the ~~Medical Assistance~~ SoonerCare Application form or ~~Form~~ OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If ~~Form~~ OKDHS form 08MA005E is received and an application cannot be completed, receipt of ~~Form~~ OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The ~~member~~ applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application.** When an application is made online, the date of application is the date the application is

submitted online. When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or ~~Form~~ OKDHS form 08MA005E is stamped into the ~~county office~~ OHCA Eligibility Unit. When an application is faxed, the application date is the date the fax is received. When a request for SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be ~~shown on the computer form~~ used. When ~~Form~~ OKDHS form 08MA005E is received in the county office or the OHCA Eligibility Unit prior to the completion of the application form, the date that ~~Form~~ OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OKDHS county office or the OHCA Eligibility Unit for SoonerCare eligibility determination. Under this circumstance, the application date is the date the member signed the application form for the provider.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60.1. Certification for the Family Planning Waiver Program.

The effective date of certification for the Family Planning Waiver Program is the ~~first day of the month~~ date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the Family Planning Waiver Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.

317:35-7-63. Notification of eligibility

When eligibility for ~~short-term medical care~~ SoonerCare is established, the ~~county office updates the computer form and~~ the appropriate notice is computer generated to the ~~client and provider~~ applicant. When the computer file is updated for changes, notices are generated only if there is a change in the ~~client's financial responsibility~~ SoonerCare eligibility of a household member.

317:35-7-64. Denials

If denial of ~~medical care~~ SoonerCare is for ~~an entire family case~~ the entire household, the ~~computer input form~~ application is ~~updated~~ denied and the appropriate notice is computer generated to the ~~client and provider~~ applicant. If an individual(s) is being denied but other family members are eligible, the ~~county provides the~~ denied individual(s) is provided with a notice ~~using the Notification of Eligibility Status for Medical Assistance form~~.

317:35-7-65. Closures

~~Short-term medical care~~ SoonerCare cases are closed ~~by the county~~ at any time during the certification period that the case becomes ineligible. A computer-generated notice is sent to the ~~client and the provider~~ head of the household. Otherwise, a case automatically closes at the end of the certification period if eligibility is not redetermined ~~with the exception of~~ except for children in the custody of ~~DHS~~ OKDHS who are placed outside their own home.

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-9. Notification of eligibility

When eligibility for the pregnancy benefits covered under Title XXI is established, the ~~OKDHS county office updates the computer form and the~~ appropriate notice is computer generated to the member.

317:35-22-11. Closures

~~Health benefit~~ SoonerCare cases are closed ~~by the OKDHS county office~~ at any time during the certification period that the ~~case~~ member becomes ineligible. A computer-generated notice is sent to the member.

[OAR Docket #10-786; filed 5-7-10]

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

[OAR Docket #10-779]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-2. [AMENDED]
317:35-5-7. [AMENDED]
Part 5. Countable Income and Resources
317:35-5-43. [AMENDED]
317:35-5-44. [AMENDED]
Subchapter 10. ~~Medical Aid to Families with Dependent Children~~Other Eligibility Factors for Families with Children and Pregnant Women
Part 5. Income
317:35-10-26. [AMENDED]
Subchapter 17. ADvantage Waiver Services
317:35-17-3. [AMENDED]
Subchapter 21. Breast and Cervical Cancer Treatment Program
317:35-21-11. [AMENDED]
(Reference APA WF # 09-20)
AUTHORITY:
The 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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December 16, 2009 through January 14, 2010
Public hearing:
January 19, 2010

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March 12, 2010
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Legislative approval:
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Subchapter 10. Medical Aid to Families with Dependent Children
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(Reference APA WF # 09-56B)
INCORPORATIONS BY REFERENCE:
N/A
ANALYSIS:
Medical Assistance for Adults and Children-Eligibility rules are revised to clarify rules used by employees of the Oklahoma Department of Human Services (OKDHS) and the Oklahoma Health Care Authority (OHCA) when determining an individual's eligibility for Medicaid. The proposed revisions will: (1) incorporate current procedures and terminology; (2) remove obsolete language; and (3) update incorrect policy citations and form references. Revisions are needed to provide consistency and clarify within agency rules.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIP

317:35-5-2. Categorically related programs

(a) Categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, or is ~~low income~~ under age 19, categorical relationship is automatically established. Categorical relationship to pregnancy-related services is established when the determination is made by medical evidence that the individual is or has been pregnant. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods. For an individual age 19 or over to be related to AFDC, the individual must have a minor dependent child. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the Family Planning Waiver Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one of the following:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Aid to Families with Dependent Children
(6) Refugee
(7) Breast and Cervical Cancer Treatment program
(8) Family Planning Waiver Program
(9) Benefits for pregnancies covered under Title XXI.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21 who are not receiving cash assistance under any program but who meet the income requirement of the State's approved AFDC plan.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:

(A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

(B) in adoptions subsidized in full or in part by a public agency; or

(C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan

and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

317:35-5-7. Determining categorical relationship to AFDC

(a) All individuals under age 19 are automatically related to AFDC and further determination is not required. Adults age 19 or older are related to AFDC when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age and relationship.

(b) ~~CSED~~ **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving ~~Medicaid benefits~~ SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with ~~CSED~~ OCSS. However, federal regulations provide for a waiver of this requirement when cooperation with ~~CSED~~ OCSS is not in the best interest of the child. ~~CSED~~ OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, his/her needs cannot be included in the benefit group unless ~~CSED~~ OCSS has determined good cause exists. There is no requirement of cooperation with ~~CSED~~ OCSS for a child(ren) only ~~Medicaid~~ SoonerCare case.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-43. Third party resources; insurance, workers' compensation and Medicare

Federal Regulations require that all reasonable measures to ascertain legal liability of third parties to pay for care and services be taken. In instances where such liability is found to exist after ~~Title XIX~~ SoonerCare has been made available, reimbursement to the extent of such legal liability must be sought. ~~If the~~ The applicant or ~~recipient~~ member ~~has already received payments~~ must fully disclose to OHCA that another resource may be available to pay for care. If OKDHS obtains information regarding other available resources from a third party, the worker must complete OKDHS Form 08AD050E, ~~Third Party Liability Resources, is completed by OKDHS staff~~ and ~~submitted~~ submit to OHCA, Third Party Liability Unit. Certification or payment in behalf of an eligible individual may not be withheld because of the liability of a third party when such liability or the amount cannot be currently established or is not currently available to pay the individual's medical expense. The rules in this Section also apply when an individual categorically related to pregnancy-related services plans to put the child up for adoption. Any agreement with an adoption agency or attorneys shall include ~~for~~ payment of medical care and must be determined as a possible third party liability, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting SoonerCare is responsible for identifying and providing information on any private medical insurance. He/she is also responsible for reporting subsequent changes in insurance coverage. ~~The worker must explain the necessity for applying benefits from private insurance to the cost of medical care.~~

(B) **Government benefits.** ~~When an individual~~ Individuals requesting SoonerCare ~~is~~ who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), ~~payment is not made from SoonerCare funds until the worker receives confirmation that other benefits are not available from this source~~ must disclose that the coverage is available. Payments from CHAMPUS for medical care are not considered as income in determining eligibility. They are, however, considered as third party liability sources.

(2) **Workers' Compensation.** ~~When an~~ An applicant for SoonerCare or a SoonerCare member that requires medical care because of work injury or occupational disease~~, the worker~~ must notify OHCA/TPL immediately and assist OHCA in ~~ascertains~~ ascertaining the facts related to the injury or disease (such as date, details of the accident, etc.) ~~and sends OKDHS Form 08AD050E to OHCA/TPL to be referred to the OKDHS Audit Unit of OIG~~. The ~~OKDHS Legal Division clears~~ OHCA periodically matches data with the ~~Industrial~~ Worker's Compensation Court on all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or a SoonerCare member is obtained, ~~the OKDHS Legal Division sends a memo to OHCA asking for an itemization of claims paid~~ OHCA must then attempt to subrogate with the employer/insurer.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a SoonerCare member as the result of an accident or injury known to the worker, the ~~worker~~ member is responsible for ~~determining~~ reporting to OHCA/TPL the persons involved in the accident, date and details of the accident and possible insurance benefits which might be made available. If an automobile accident involves more than one car it is necessary to report liability insurance on all cars involved.

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, ~~The~~ the worker completes OKDHS Form 08AD050E and submits it with any additional information available to ~~the appropriate OKDHS State Office Division where it is referred to the OKDHS Audit and Review Division for determination of liability for medical care. A copy of this referral is sent to OHCA, Third Party Liability~~ OHCA/TPL.

(B) If ~~such report has not been received from the county but the~~ OHCA receives a claim for payment from SoonerCare funds and the diagnosis indicates the ~~possibility the~~ need for services may have resulted from an accident or injury involving third party liability, OHCA ~~sends this information to the OKDHS Office of Inspector General.~~ will attempt to contact the member to obtain details of the incident. If additional contact is necessary with the member, ~~The~~ the local office may be requested by the ~~OKDHS Audit and Review Division~~ OHCA/TPL to submit OKDHS Form 08AD050E. The worker completes this form and submits it to the ~~OKDHS State Office, where the OKDHS Office of Inspector General will make any necessary follow up and~~ OHCA/TPL to take the appropriate action.

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the worker clears with the Social Security Office and enters the findings and the date of the verification in the case record. If the applicant did not enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is not required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to AFDC, AB or AD and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS ~~DCFS~~ Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

(i) In the event the family already has an existing ~~Child Support Enforcement~~ child support case, the only action required is a memo to the appropriate ~~Child Support Enforcement~~ Oklahoma Child Support Services (OCSS) district office notifying them of the certification.

(ii) Child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the ~~CSED~~ OCSS or retained by the member.

(iii) Children who are in custody of OKDHS may be exempt from referral to ~~CSED~~ OCSS. Should the pursuit of the ~~CSED~~ OCSS services be determined to be detrimental to the OKDHS ~~DCFS~~ CFSD service plan, an exemption may be approved.

(B) Cash medical support may be ordered to be paid to the OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to OKDHS Rules. Reasonable is deemed to be 5% or less of the non-custodial parent's gross income. The administration and collection of cash medical support will be determined by OKDHS ~~CSED~~ OCSS and will be based on the income guidelines and rules that are applicable at the time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to ~~OKDHS CSED~~ OKDHS/OCSS guidelines.

317:35-5-44. Child/spousal support

The Omnibus Budget Reconciliation Act of 1987 requires the Oklahoma Department of Human Services to provide Child Support ~~Enforcement~~ Services to certain families receiving ~~Medicaid~~ SoonerCare benefits ~~(MA, AB, AD)~~ through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights. These families will not be required to cooperate with the ~~Department of Human Services~~ OCSS in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to AFDC, AB or AD and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in ~~DHS~~ OKDHS temporary custody. This support is paid to ~~DHS DCFS~~ OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining ~~Medicaid~~ SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

(1) In the event the family already has an existing ~~Child Support Enforcement~~ child support case, the only action required is a memo to the appropriate ~~Child Support Enforcement~~ OCSS district office notifying them of the certification.

(2) Child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the ~~CSED~~ OCSS or retained by the ~~client~~ member.

(3) Children who are in custody of ~~DHS~~ OKDHS may be exempt from referral to ~~CSED~~ OCSS. Should the pursuit of the ~~CSED~~ OCSS services be determined to be detrimental to the ~~DHS DCFS~~ OKDHS CFSD service plan, an exemption may be approved.

SUBCHAPTER 10. ~~MEDICAL AID TO FAMILIES WITH DEPENDENT CHILDREN~~ OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 5. INCOME

317:35-10-26. Income

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to AFDC or Pregnancy does not require verification, unless questionable. If the income information is questionable, ~~the worker must verify the income~~ it must be verified. ~~The worker views all data exchange screens on all individuals included in the household size.~~ If ~~the data exchange screen reveals conflicting information, the worker must resolve the conflicting information and if necessary, request verification~~ there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Department of Human Services (OKDHS). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within 30 days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. Pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) A nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to an AFDC or pregnancy related recipient who is not currently eligible for SSI, is not counted as income.

~~(B) The worker must ask applicants if they have received a lump sum payment during the month of application, any month during the application process or anticipate to receive a lump sum in the future. Members are asked at the time of periodic redetermination if the benefit group has received or is expecting to receive a lump sum. The worker provides an oral explanation, including examples of lump sum payments, how the rule effects other benefits and the importance~~

~~of reporting anticipated receipt of a lump sum payment. The worker also offers counseling when there is indication of anticipated receipt, including voluntary withdrawal of the application or case closure and availability of free legal advice.~~

(~~C~~B) Lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award.

(~~D~~C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy.

(~~E~~D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(~~F~~E) Recurring lump sum income received from any source for a period covering more than one month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(~~G~~F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six months, will be averaged and considered as income for the next six months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two months to establish the amount to be anticipated and considered for prospective budgeting.

(6) A caretaker relative can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the ~~natural or~~ biological or adoptive parent is either incapacitated or not in the home.

(A) Consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children ~~regardless of whether the caretaker relative's needs are or are not included~~. However, if that person is the stepparent, the policy on stepparent liability is applicable.

(B) If a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the ~~relative~~ caretaker relative. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month.

(7) A stepparent can be included when the ~~natural or~~ biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included.

(8) When there is a stepparent or person living in the home with the ~~natural~~ biological or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent ~~but who is acting in the role of a spouse~~, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded as income. When the individual and the member state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the ~~"true~~ wage~~"~~ prior to payroll deductions and/or withholdings.

(1) **Earned income from self-employment.** If the income results from the ~~individuals's~~ individual's activities primarily as a result of the ~~individuals's~~ individual's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.

(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.

(i) The federal or state income tax form for the most recent year is used for calculating the income~~, if necessary,~~ only if it is representative of the individual's current situation. The individual's business records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.

(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in operation to establish the monthly income amount.

(iii) Self-employment income which represents an annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(B) **Items not considered.** The following items are not considered as a cost of producing self-employed income:

(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;

(ii) Net losses from previous periods;

(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and

(iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.

(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside-person or agency.

(2) **Earned income from wages, salary or commission.** If the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income.

(3) **Earned income from work and training programs.** Earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year.

(4) **Individual earned income exemptions.** Exemptions from each individual's earned income include a monthly standard work related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.

(A) **Work related expenses.** The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group.

(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.

(i) Child care expense may be deducted when:

(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and

(II) the employed member whose income is considered must purchase care.

(ii) ~~Child care expenses must be verified and the~~ The actual amount paid for child care per month, ~~as paid,~~ up to a maximum of $200 for a child under the age of two or $175 for a child age two or older may be deducted. ~~In considering the care expense, only actual work hours and travel time between work and the child care facility or child care home will be allowed.~~

~~(iii) In explaining child care expenses, the worker informs the individual that payment for care is the responsibility of the member and any changes in the plan for care must be reported immediately.~~

(~~iv~~ iii) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home

provider. ~~However, in cases where licensed dependent care facilities and/or approved in home providers are not available (e.g., night employment), and the member arranges for care outside the home, an immediate referral is made by OKDHS Form K-13 to the licensing worker for a licensing decision. The cost of child care can be considered until the worker receives notification from the licensing worker that the home does not meet licensing standards or registration. If licensing or registration is denied, the member will be allowed 30 days after notification to make other child care arrangements, during which time the child care exemption will continue to be allowed.~~

(~~v~~ iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the home meets applicable standards of State, local or Tribal law.

(~~vi~~ v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(5) **Formula for determining the individual's net earned income.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(c) **Unearned income.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA. ~~If the individual states that he/she does not receive OASDI, has a pending application or has been denied OASDI, this can be verified, if necessary, by use of TPQYC computer transaction.~~ Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed $30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached $30. At that time the portion exceeding $30 is counted as lump sum income. If the amount of a single gift exceeds $30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

(10) **Funds held in trust by Bureau of Indian Affairs (BIA).** The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the social worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered. Funds held in trust by the BIA and not disbursed are considered unavailable.

(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as income.

(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate

all or a portion of the account may be available to the individual member, guardian or conservator.

(C) When disbursements have been made, the worker verifies whether such disbursements were made to the member or to a third party vendor in payment for goods or services. Payments made directly from the BIA to vendors are not considered as income to the member. Workers obtain documentation to verify services rendered and payment made by BIA.

(D) Amounts disbursed directly to the members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is counted in the month received.

(d) **Income disregards.** Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education Grants (including work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form ~~ADM 103~~ 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form ~~Adm 103~~ 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;

(5) Indian payments (including judgement funds or funds held in trust) which are distributed per capita by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this paragraph, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;

(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;

(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;

(9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;

(12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;

(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;

(14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(15) Earnings of a child who is a full-time student are disregarded;

(16) The first $50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;

(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;

(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;

(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;
(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;
(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by states, local governments and disaster assistance organizations;
(24) Interests of individual Indians in trust or restricted lands;
(25) Income up to $2,000 per year received by individual Indians, which is derived from leases or other uses of individually-owned trust or restricted lands;
(26) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);
(27) Any payments made directly to a third party for the benefit of a member of the benefit group;
(28) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;
(29) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and an other such complimentary payments; ~~and~~
(30) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(31) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);
(32) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
(33) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
(34) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and
(35) Wages paid by the Census Bureau for temporary employment related to Census activities.

(e) In computing monthly income, cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplies by 4.3.
(2) **Weekly.** Income received weekly is multiplied by 4.3.
(3) **Twice a month.** Income received twice a month is multiplied by 2.
(4) **Biweekly.** Income received every two weeks is multiplied by 2.15.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ADvantage program ~~clients~~ members must be ~~Medicaid~~ SoonerCare eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center. The number of ~~clients~~ individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:
(A) be age 65 years or older, or
(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or
(C) if developmentally disabled and between the ages of 21 and 65, not have mental retardation or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet the following criteria:
(A) require nursing facility level of care [see OAC 317:35-17-2];
(B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and
(C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of ~~state plan~~ Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable ~~Medicaid~~ SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate ~~Medicaid~~ SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap. To meet program cost effectiveness eligibility criteria, the annualized cost of a ~~client's~~ individual's ADvantage services cannot exceed the ADvantage program services expenditure cap unless approved by the ~~Administrative Agent (AA) under one of~~ Oklahoma DHS Aging Services Division (OKDHS/ASD) in accordance with the exceptions listed in (1)- (5) of this subsection. The cost of the service plan furnished to ~~a client~~ an individual may exceed the expenditure cap only when all of the increased expenditures above the cap are due solely to:

(1) a one-time purchase of home modifications and/or specialized medical equipment; and/or

(2) documented need for a temporary (not to exceed a 60-day limit) increase in frequency of service or number of services to prevent institutionalization; or

(3) expenditures are for ADvantage Hospice services;

(4) expenditures in excess of the cap are for prescribed drugs, which would be paid by ~~Medicaid~~ SoonerCare if the individual were receiving services in a nursing home; and/or

(5) expenditures are for Institution Transition Services, and the annualized expenditures for ADvantage services to ~~a client~~ an individual under any combination of ~~these~~ circumstances described under exceptions (1) through (5) can reasonably be expected to be no more than 200% of the individual cap.

(c) Services provided through the ADvantage waiver are:

(1) case management~~ or Comprehensive Home Care (CHC) case management~~;

(2) respite~~ or CHC in-home respite~~;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy/occupational therapy/respiratory therapy/speech therapy or consultation;

(7) advanced supportive/restorative assistance~~ or CHC advanced supportive/restorative assistance~~;

(8) skilled nursing~~ or CHC skilled nursing~~;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) personal care (state plan)~~,~~ or ADvantage personal care~~, or CHC personal care~~;

(13) Personal Emergency Response System (PERS);

(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);

(15) Institution Transition Services;~~ and~~

(16) assisted living; and

(~~16~~ 17) ~~Medicaid~~ SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

(d) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the ~~client~~ individual. If the ~~AA~~ OKDHS/ASD determines all ADvantage waiver slots are filled, the ~~client~~ individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the ~~client's~~ individual's name is placed on a waiting list for entry as an open slot becomes available. ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.

(2) the ~~client~~ individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have mental retardation or a cognitive impairment.

(3) the ~~client~~ individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the ~~client~~ individual or other household visitors.

(e) The ~~AA~~ OKDHS/ASD determines ADvantage program eligibility through the service plan approval process. The following criteria are used to make the ADvantage program eligibility determination that ~~a client~~ an individual is not eligible:

(1) if the ~~client's~~ individual's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver ~~client's~~ individual's health, safety, or welfare can be maintained in their home. If a ~~client's~~ member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the ~~client's~~ individual's health, safety or welfare in their home cannot be assured.

(2) if the ~~client~~ individual poses a physical threat to self or others as supported by professional documentation.

(3) if 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~~ individual or other household visitors.

(4) if the ~~client's~~ individual's needs are being met, or do not require ADvantage services to be met, or if the ~~client~~ individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to ~~client~~ individual's health and safety is not acceptable to the ~~client~~ individual, or to the interdisciplinary service plan team, or to the ~~AA~~ OKDHS/ASD.

(f) The case manager provides the ~~AA~~ OKDHS/ASD with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the ~~client~~ individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the ~~AA~~ OKDHS/ASD will provide technical assistance to the Provider for transitioning the ~~client~~ individual to other services.

(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

~~(h) The AA provides OKDHS with notification that the client is no longer program eligible.~~

SUBCHAPTER 21. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

317:35-21-11. Certification for BCC

(a) In order for a woman to receive BCC treatment services she must first be screened for BCC under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to be in need of treatment. Once determined to be in need of treatment the CDC screener determines that the woman:

(1) does not have creditable health insurance coverage,

(2) is under age 65,

(3) is a US citizen or qualified alien (see OAC 317:35-5-25),

(4) is a self declared Oklahoma resident,

(5) has provided her social security number,

(6) is willing to assign medical rights to TPL, and

(7) has declared all household income.

(b) If all of the conditions in subchapter (a) are met, the CDC screener assists the woman in completing the BCC application (OHCA BCC-1). The completed BCC-1 is forwarded to the OKDHS office.

(c) If all of the conditions in subchapter (a) are not met, an application is not completed.

(d) The OKDHS worker verifies that the screener is a CDC screener. The worker also establishes whether or not the woman is otherwise eligible for ~~Medicaid~~ SoonerCare. If the woman is not otherwise eligible for ~~Medicaid~~ SoonerCare, she is certified for the BCC program. If the woman is eligible under another ~~Medicaid~~ SoonerCare category, the application is certified in ~~the other Medicaid~~ that category.

(e) If a woman does not cooperate in determining her eligibility for other ~~Medicaid~~ SoonerCare programs, her BCC application is denied and the appropriate notice is computer generated. For example, a woman otherwise eligible for ~~Medicaid~~ SoonerCare, related to the low income families with children category, refuses to cooperate with ~~child support enforcement~~ the Oklahoma Child Support Services Division without good cause would not be eligible for the BCC program.

(f) If a woman in treatment for breast or cervical cancer contacts
the OKDHS office and has not been through the CDC screening process, she is referred to the BCC program.

(g) An individual determined eligible for BCC may be certified the first day of the month of application or, if the individual had a medical service within three months prior to the application date, the first day of the first, second or third month prior to the month of application, provided the date of certification is not prior to the CDC Screen.

[OAR Docket #10-779; filed 5-7-10]

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

[OAR Docket #10-785]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 5. Eligibility and Countable Income
Part 3. Non-Medical Eligibility Requirements
317:35-5-25. [AMENDED]
Subchapter 6. SoonerCare ~~Health Benefits~~ for Categorically Needy Pregnant Women and Families with Children
Part 7. Certification, Redetermination and Notification
317:35-6-60. [AMENDED]
317:35-6-61. [AMENDED]
(Reference APA WF # 09-55)
AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 111-08; 42 CFR 435.117; Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-03
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N/A
ANALYSIS:

SoonerCare citizenship rules are revised to extend the time limited benefit period for Afghans with special immigrant status from six to eight months. Congress enacted Public Law 111-08 (Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 2009) on March 10, 2009, which lengthened the six month period of Medicaid for Afghan special immigrants to eight months. Rules are amended to assure that eligible Afghan individuals receive SoonerCare benefits for the correct period of time under federal regulation.

SoonerCare eligibility rules regarding coverage for deemed newborns are revised to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. The Deficit Reduction Act of 2005 added specific citizenship and identify documentation requirements in order for individuals to qualify for Medicaid. Public Law 111-3 provides that children who were initially eligible for Medicaid as deemed newborns shall be considered to have provided satisfactory documentation of citizenship and identity when their eligibility is renewed on their first birthday. The legislation further eliminates the requirement that, in order to receive coverage, newborns coming home from the hospital must live with the mother, remain a member of the mother's household, and that the mother remain eligible for Medicaid (or would remain eligible if still pregnant). Rules are revised to state that a deemed newborn will be regarded as meeting the citizenship and identity requirements for all future SoonerCare eligibility determinations. Further, the certification period for the deemed newborn will be shortened only in the event the child the loses Oklahoma residence or expires. Other revisions clarify that deemed newborns are to be certified for SoonerCare through the end of the month that the child reaches age one.

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 11, 2010:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/alien status and identity verification requirements

(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for ~~Medicaid~~ SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) Passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS) (Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ID Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma Voter Registration Card; or

(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;

(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for ~~Medicaid~~ SoonerCare. This evidence must be one of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;

(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;

(III) U.S. State Vital Statistics official notification of birth registration;

(IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or

(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

(B) A school identification card with a photograph of the individual;

(C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under 16, school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and **cannot be used if an affidavit for citizenship was provided.**

(b) **~~Centralized Verification Unit~~ Reasonable opportunity to obtain citizenship verification.**

(1) When the applicant/member is unable to obtain citizenship verification, a reasonable opportunity is afforded the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded the applicant/member before taking action affecting the individual's eligibility for ~~Medicaid~~ SoonerCare. The reasonable opportunity time frame usually consists of 60 days. In rare instances, the ~~CVU may extend the~~ time frame may be extended to a period not to exceed an additional 60 days.

(2) ~~Additional~~ The following methods of verification are ~~available to the CVU. These methods are~~ the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution.

Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five years before the initial application date that indicates a U.S. place of birth. For children under 16, the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim or citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements.** ~~Medicaid~~ SoonerCare services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility.

(1) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of ~~Medicaid~~ SoonerCare services. A qualified alien is:

(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five years from the date of entry and who was:

(i) lawfully admitted for permanent residence under the Immigration and Nationality Act;

(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;

(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or

(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who was:

(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;

(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;

(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;

(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;

(v) an alien who is a veteran as defined in 38 U.S.C. § 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;

(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;

(vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph.

(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or

(ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful permanent residence status.

(2) **Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for ~~Medicaid~~ SoonerCare for five years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) **Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are

exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Afghan special immigrants is ~~six~~ eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the eight month exemption period ends, Afghan special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Afghan special immigrants are considered lawful permanent residents.

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Iraqi special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the eight month exemption period ends, Iraqi special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Iraqi special immigrants are considered lawful permanent residents.

(5) **Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(6) **Ineligible aliens.**

(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for ~~Medicaid~~ SoonerCare, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(B) These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record - Parole Edition". Two other forms that do not give the individual "Immigrant" status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.

(7) **Preauthorization.** Preauthorization is required for payment of emergency medical services rendered to non-qualified and undocumented aliens. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).

(d) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.

(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the BCIS. These are individuals who entered this country with the express intention of residing here permanently.

(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for ~~Medicaid~~ SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or

(B) The following court-ordered notice sent by BCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in Silva vs. Levi, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".

(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the BCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section.

(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by BCIS. They are eligible for emergency services only.

SUBCHAPTER 6. SOONERCARE ~~HEALTH BENEFITS~~ FOR CATEGORICALLY NEEDY PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare ~~Health Benefits~~ for pregnant women and families with children

An individual determined eligible for SoonerCare ~~Health Benefits~~ may be certified for a medical service provided on or after the ~~first day of the month of application~~ date of certification. The period of certification may not be for a retroactive ~~months~~ period unless otherwise prior approved by OHCA. ~~The certification period in family cases is assigned for the shortest period of eligibility determined for any individual in the case. However, the~~ The individual who is categorically needy and ~~categorically~~ related to pregnancy-related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other ~~certification periods~~ household members in the case.

(1) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(2) **Certification of non-cash assistance individuals categorically needy and ~~categorically~~ related to AFDC.** The certification period for the individual ~~categorically~~ related to AFDC is 12 months. The certification period can be less than 12 months if the individual:

(A) is certified as eligible in a money payment case during the 12-month period;

(B) is certified for long-term care during the 12-month period;

(C) becomes ineligible for ~~medical assistance~~ SoonerCare after the initial month; or

(D) becomes ineligible as categorically needy.

(i) If an income change after certification causes the case to exceed the categorically needy maximums, the case is closed.

(ii) Individuals, however, who are determined pregnant and eligible as categorically needy continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy related services through the postpartum period.

(3) **Certification of individuals categorically needy and ~~categorically~~ related to pregnancy-related services.** The certification period for the individual ~~categorically~~ related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two months following the month the pregnancy ends. Eligibility as categorically needy is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(4) **Certification of newborn child deemed eligible.**

(A) ~~A~~ Every newborn child is deemed eligible on the date of birth for ~~Medicaid benefits~~ SoonerCare when the child is born to a woman who is eligible for pregnancy-related services as categorically needy. ~~(For purposes of this subparagraph, a newborn child is defined as any child under the age of one year.)~~ The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's

coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one. The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(B) The newborn child is deemed eligible for ~~Medicaid only~~ SoonerCare as long as he/she continues to live in Oklahoma ~~with the mother~~. No other conditions of eligibility are applicable, including social security number enumeration, ~~and~~ child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to ~~DHS Child Support Enforcement Division (CSED)~~ the Oklahoma Child Support Services (OCSS) division at OKDHS. The referral enables ~~Child Support Services~~ child support services to be initiated.

~~(C) During the original eligibility determination process for pregnancy-related services, the worker informs the mother that the newborn child will be deemed eligible on the date of birth. The mother is also advised of the importance of her reporting the newborn child's birth immediately so deeming can be done timely.~~

(~~D~~ C) When a categorically needy newborn child is deemed eligible for ~~Medicaid~~ SoonerCare, he/she ~~is added for a certification period of 13 months. The certification period expires at~~ remains eligible through the end of the month that the newborn child reaches age one. If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

~~(i) leaves the mother's home;~~

(~~ii~~ i) loses Oklahoma residence;

~~(iii) has medical needs included in another assistance case;~~ or

(~~iv~~ ii) expires.

(~~E~~ D) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare ~~Health Benefits.~~

A periodic redetermination of eligibility for SoonerCare ~~Health Benefits~~ is required on all categorically needy cases ~~categorically~~ related to AFDC. The redetermination is made prior to the end of the initial certification period and each 12 months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.

[OAR Docket #10-785; filed 5-7-10]

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

[OAR Docket #10-780]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-42. [AMENDED]
(Reference APA WF # 09-22)
AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; the American Recovery and Reinvestment Act of 2009, Public Law # 111-5; Section 1902(r)(2) and 1931 of the Social Security Act
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INCORPORATIONS BY REFERENCE:
N/A

ANALYSIS:

Rules are revised to exempt $25.00 per week in unemployment compensation for job seeking Oklahomans, as allowed by the American Recovery and Reinvestment Act of 2009. The additional $25.00 per week of regular unemployment compensation will be paid to unemployed Oklahomans through June 30, 2010, as well as an additional amount of emergency unemployment compensation through May 31, 2010. The bill mandates that the additional compensation shall not be considered in determining eligibility for Medicaid benefits. Agency eligibility rules are revised to disregard the earned income from temporary census employment. Every ten years, the Census Bureau conducts the decennial census. For the 2010 Census, the Census Bureau expects to hire more than 900,000 employees over the course of the census. Most of these employees are enumerators that conduct fieldwork who are hired very locally and who only work for a brief period of time. States are given the option by CMS to disregard this temporary income, which Oklahoma has done for the last several decennial censuses. This disregard has been added to our state plan and rules must be revised to agree with the plan.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

(2) If a husband and wife are living in their own home, the couple's total income and/or resource is divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) If only one spouse in a couple is eligible and the couple ceases to live together, ~~consider~~ only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live together are considered.

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1~~4~~ - 49~~4~~ cents is rounded down, and 50~~4~~ - 99~~4~~ cents is rounded up). For example, an individual's weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

(b) **Income disregards.** In determining need, the following are not considered as income:

(1) The coupon allotment under the Food Stamp Act of 1977;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, ~~form~~ should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E ~~Loan Verification form~~ are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

(C) Proceeds of a loan secured by an exempt asset are not an asset;

(5) One-third of child support payments received on behalf of the disabled minor child;

(6) Indian payments (including judgement funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are made per capita. For purposes of this Subchapter, per

capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;

(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;

(8) Title III benefits from State and Community Programs on Aging;

(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the national School Lunch Act;

(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;

(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;

(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;

(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;

(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

(22) Income of a sponsor to the sponsored eligible alien;

(23) The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered in determining eligibility. Funds held in trust by the BIA and not disbursed are considered unavailable.

(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as unearned income.

(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual member, guardian or conservator. When the county office is unable to resolve the situation with the BIA, the county submits a referral to the appropriate section in OKDHS Family Support Services Division (FSSD). The referral must include specific details of the situation, including the county's efforts to resolve the situation with the BIA. If FSSD cannot make a determination, a legal decision regarding availability will be obtained by FSSD, and then forwarded to the county office by FSSD. When a referral is sent to FSSD, the funds are considered as unavailable with a legal impediment until the county is notified otherwise.

(C) At each reapplication or redetermination, the worker is to contact BIA to obtain information regarding any changes as to the availability of the funds and any information regarding modifications to the IIM account. Information regarding prior disbursements is also obtained at this time. All of this information is reviewed for the previous six or twelve-month period, or since the last contact if the contact was within the last certification or redetermination period.

(D) When disbursements have been made, the worker determines whether such disbursements were made to the member or to a third party vendor in payment for goods or services. Payments made directly from the BIA to vendors are not considered as income to the member. Workers should obtain documentation to verify services rendered and payment made by BIA.

(E) Amounts disbursed directly to the members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received;

(24) Income up to $2,000 per year received by individual Indians, which are derived from leases or other uses of individually-owned trust or restricted lands;

(25) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

(26) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

(27) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;

(28) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;

(29) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);

(30) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183); ~~and~~

(31) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419)~~.~~ ;

(32) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

(33) Wages paid by the Census Bureau for temporary employment related to Census activities.

(c) **Determination of income.** The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income~~,~~ (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of ~~medical assistance~~ SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the ~~medical assistance~~ SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the member's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS ~~Appendix C-2-A~~ Form 08AX011E.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.

(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an

attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the $90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) **Income from capital resources and rental property.** Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two month's royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from rent property is treated as unearned income.

(iii) When property rental is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) **Earned income/self-employment.** The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services; e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind

but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Advance payments of EITC or refunds of EITC received as a result of filing a federal income tax return are considered as earned income in the month they are received.

(ii) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

(iii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business expense and appropriate earned income disregards.

(iv) Self-employment income is determined as follows:

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount as well as the allowable deductions are the same as can be claimed under the Internal Revenue code for tax purposes.

(II) Self-employment income which represents a household's annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.

(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).

(v) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(ii) **Weekly.** Income received weekly is multiplied by 4.3.

(iii) **Twice a month.** Income received twice a month is multiplied by 2.

(iv) **Biweekly.** Income received every two weeks is multiplied by 2.15.

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.

(d) **Computation of income.**

(1) **Earned income.** The general income exclusion of $20 per month is allowed on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income.

(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.

(3) **Countable income.** The countable income is the sum of the earned income after exclusions and the total gross unearned income.

(4) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) A mentally retarded child living in the home who is ineligible for SSP due to the deeming process may be approved for ~~Medical Assistance~~ SoonerCare under the Home and Community Based Services Waiver (~~HCBW~~ HCBS) Program as outlined in OAC 317:35-9-5.

(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

(5) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income ~~are~~ is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

(6) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS ~~Appendix C-1~~ Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.

(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.

(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

(7) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

[OAR Docket #10-780; filed 5-7-10]

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

[OAR Docket #10-792]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 15. Personal Care Services
317:35-15-13.2. [AMENDED]
Subchapter 17. ADvantage Waiver Services
317:35-17-22. [AMENDED]
(Reference APA WF # 09-65B)
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The 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:
Rules are revised to require the use of the new Interactive Voice Response Authentication (IVRA) system to document time and attendance for all Personal Care and certain in-home ADvantage services provided to SoonerCare members. In-home services are necessarily provided in the individual homes of persons with physical and cognitive disabilities. The verification of service delivery is typically a paper time sheet signed by the member receiving services with a high potential for errors. Additionally, a paper based time and attendance system which requires transcription of time units from paper to computer is both inefficient and affords many opportunities for inadvertent errors.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-13.2. Individual Personal Care contractor; billing, training, and problem resolution

While OHCA is the contractor authorized under federal law, the Oklahoma Department of Human Services (OKDHS) initiates initial contracts with qualified individuals for provision of Personal Care services as defined in OAC 317:35-15-2. The contract renewal for the PCA is the responsibility of the Oklahoma Health Care Authority (OHCA).

(1) **Payment for Personal Care.** Payment for Personal Care is generally made for care in the ~~client's~~ member's own home. A rented apartment, room or shelter shared with others is considered "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. Personal Care may not be approved if the ~~client~~ member lives in the PCA's home except with the interdisciplinary team's written approval. The potential individual PCA must meet the minimum requirements under (2) of this subsection. With ~~DHS~~ 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.

(A) **Reimbursement.** Personal Care payment for a ~~client~~ member is made according to the number of units of service identified in the service plan.

(i) The unit amounts paid to individual contractors is according to the established rates. 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~~ member. The service plans will combine units in the most efficient manner to meet the needs of all eligible persons in the household.

(ii) From the total amounts billed by the individual PCA in (i) of this subparagraph, the OHCA (acting as agent for the ~~client-employer~~ member-employer) withholds the appropriate percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To assure that the individual contractor's social security account may be properly credited, it is vital that the individual contractor's social security number be entered correctly on each claim. In order for the OHCA to withhold FICA tax, the LTC nurse must obtain a signed OHCA Form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, from the ~~client~~ member as soon as the area nurse, or designee, has approved Personal Care. A copy of the signed HCA-66 must be in the case record. A signed OHCA-0026, Personal Care Program Individual Contract, must be on file with the OHCA before the individual contractor's first claim can be submitted.

(iii) 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 is made for direct services and care of the eligible ~~client(s)~~ member(s) only. The area nurse, or designee, authorizes the number of units of service the ~~client~~ member receives each month.

(iv) A ~~client~~ member may select more than one individual contractor. This may be necessary as indicated by the service and care plans.

(v) The individual contractor may provide ~~Medicaid~~ SoonerCare Personal Care services for several households during one week, as long as the daily number of paid service units do not exceed eight per day. The total number of hours per week cannot exceed 40.

(B) **Release of wage and/or employment information for individual contractors.** Any inquiry received by the local office requesting wage and/or employment information for an individual Personal Care contractor will be forwarded to the OHCA, Claims Resolution.

(2) **~~Client~~ Member selection of individual PCA.** ~~Clients~~ Members and/or family members recruit, interview, conduct reference checks, and select the individual to be considered as an individual contractor. An individual contractor applicant must have a background check performed by the Oklahoma State Bureau of Investigation

(OSBI). The results of the background check determine whether a person will be permitted to work as an individual Personal Care contractor. According to Section 1025.2 of Title 56 of the Oklahoma Statutes, before the ~~client~~ member employer makes an offer to employ or contract with a ~~Medicaid~~ SoonerCare Personal Care Assistant applicant to provide Personal Care Services to a person who receives ~~state Medicaid~~ SoonerCare Personal Care Services, the ~~DHS~~ OKDHS LTC nurse, acting for the ~~client~~ member, must check the ~~DHS~~ OKDHS Community Services Worker Registry to determine if the name of the applicant seeking employment or contract has been entered. The ~~DHS~~ OKDHS LTC nurse must also check the Certified Nurse Aid Registry. The ~~DHS~~ OKDHS LTC nurse must affirm that the applicant's name is not contained on either registry. The LTC nurse will notify the OHCA if the applicant is on the registry.

(A) **Persons eligible to serve as individual Personal Care Assistants.** Payment is made for Personal Care Services to an individual who:

(i) is at least 18 years of age,

(ii) has no pending notation related to abuse, neglect or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry,

(iii) is not included on the ~~DHS~~ OKDHS Community Services Worker Registry in accordance with Section 1025.2 of Title 56, of Oklahoma Statutes,

(iv) has not been convicted of a crime as outlined in Title 63 of Oklahoma Statutes, Sections 1-1950 as determined by an OSBI background check,

(v) demonstrates the ability to understand and carry out assigned tasks,

(vi) is not a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the ~~client~~ member being served,

(vii) has a verifiable work history and/or personal references, verifiable identification, and

(viii) meets any additional requirements as outlined in the contract and certification requirements with the Oklahoma Health Care Authority.

(B) **Persons ineligible to serve as Personal Care Assistants.** Payment from ~~Medicaid~~ SoonerCare funds for Personal Care services may not be made to an individual who is a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the ~~client~~ member to whom he/she is providing personal care services.

~~(i) The DHS Director may give approval for payment from DHS state funds for Personal Care to a legally responsible family member of the client being served when no other PCA is available, available PCAs are unable to provide care to the client, or the needs of the client are so extensive that the legally responsible family member who provides the care is prohibited from working outside the home due to the client's need for care.~~

(~~ii~~ i) Payment cannot be made to a ~~DHS~~ OKDHS or OHCA employee. Payment cannot be made to an immediate family member of ~~a DHS~~ an OKDHS employee who works in the same county without OKDHS/Aging Services Division approval. When a family member relationship exists between ~~a DHS~~ an OKDHS LTC nurse and a PCA in the same county, the LTC nurse cannot manage services for a ~~client~~ member whose individual provider is a family member of the LTC nurse.

(~~iii~~ ii) If it is determined that an employee is interfering in the process of providing Personal Care Services for personal or family benefit, he/she will be subject to disciplinary action.

(3) **Orientation of the Personal Care Assistant.** When a ~~client~~ member selects an individual PCA, the LTC nurse contacts the individual to report to the county office to complete the ODH form 805, Uniform Employment Application for Nurse Aide Staff, and the ~~DHS~~ OKDHS form ~~DDS-39~~ 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation. This process is the responsibility of the LTC nurse. The PCA can begin work when:

(A) he/she has been interviewed by the ~~client~~ member,

(B) he/she has been oriented by the LTC nurse,

(C) he/she has executed a contract (OHCA-0026) with the OHCA,

(D) the effective service date has been established,

(E) the Community Service Worker Registry has been checked and the PCA's name is not on the Registry,

(F) the Oklahoma State Department of Health Nurse Aide Registry has been checked and no notations found, and

(G) the OSBI background check has been completed.

(4) **Training of Personal Care Assistants.** It is the responsibility of the LTC nurse to make sure for each client, that the PCA has the training needed to carry out the plan of care prior to service initiation.

(5) **Problem resolution related to the performance of the Personal Care Assistant.** When it comes to the attention of the LTC nurse or ~~social~~ worker that there is a problem related to the performance of the PCA, a counseling conference is held between the ~~client~~ member, LTC nurse and ~~social~~ worker. The LTC nurse will counsel the PCA regarding problems with his/her performance. Counseling is considered when the staff believe that counseling will result in improved performance.

(6) **Termination of the PCA Provider Agreement.**

(A) A recommendation for the termination of a PCA's contract is submitted to the OHCA and the services of the PCA are suspended immediately when:

(i) a PCA's performance is such that his/her continued participation in the program could pose a threat to the health and safety of the ~~client~~ member or others; or

(ii) the PCA failed to comply with the expectations outlined in the PCA Provider Agreement and counseling is not appropriate or has not been effective; or

(iii) a PCA's name appears on the ~~DHS~~ OKDHS Community Services Worker Registry, even though his/her name may not have appeared on the Registry at the time of application or hiring.

(B) The LTC nurse makes the recommendation for the termination of the PCA to the ~~OHCA Legal Division with a copy to the DHS~~ OKDHS State Office Aging Services Division who then notifies the OHCA Legal Division of the recommendation. When the problem is related to allegations of abuse, neglect, or exploitation, OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, the OHCA, and the Oklahoma State Department of Health are notified by the LTC nurse.

(C) When the problem is related to allegations of abuse, neglect or exploitation, the LTC nurse follows the process as outlined in OAC 340:100-3-39.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-22. Billing procedures for ADvantage services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The OKDHS/ASD 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 are used to 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~~ the OHCA Provider Audit Unit for follow-up investigation.

(d) Service time of Personal Care, Case Management, Case Management for transitioning, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance and Advanced Personal Services Assistance is ~~reimbursed~~ documented solely through the Interactive Voice Response Authentication (IVRA) system when provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

[OAR Docket #10-792; filed 5-7-10]

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

[OAR Docket #10-778]

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PERMANENT final adoption
RULES:
Subchapter 17. ADvantage Waiver Services
317:35-17-12. [AMENDED]
317:35-17-17. through 317:35-17-18. [AMENDED]
317:35-17-20. [REVOKED]
317:35-17-21.1. [AMENDED]
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N/A
ANALYSIS:
Rules are revised to remove references to the Long Term Care Authority as the Administrative Agent of the ADvantage Program. The Oklahoma

Department of Human Services has discontinued contracting with the Long Term Care Authority of Tulsa to perform the function as the Administrative Agent for the ADvantage Program. The Oklahoma Department of Human Services/Aging Services Division has assumed the administrative responsibility for the ADvantage Program. Rules are further revised to update definitions, terminology, and procedures.

CONTACT PERSON:

Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-12. Certification for ADvantage program services

(a) **Application date.** If the applicant is found eligible for ~~Medicaid~~ SoonerCare, certification may be effective the date of application. The first month of the certification period must be the first month the member was determined eligible for ADvantage, both financially and medically.

(1) As soon as eligibility or ineligibility for ADvantage program services is established, the worker updates the computer form and the appropriate notice is computer generated to the member and the ~~Administrative Agent~~ ADvantage Administration (AA). Notice information is retained on the notice file for county use.

(2) An applicant approved for ADvantage program services is mailed a Medical Identification Card.

(b) **Financial certification period for ADvantage program services.** The financial certification period for the ADvantage program services is 12 months. Although "medical eligibility number of months" on the computer input record will show 99 months, redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical Certification period for ADvantage program services.** The medical certification period for the ADvantage program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan by the case manager. In addition, an independent evaluation of medical eligibility is completed by the OKDHS Nurse at least every third year. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, the OKDHS Nurse does an independent evaluation of medical eligibility before the end of the current medical certification period.

317:35-17-17. Supplemental process for expedited eligibility determination (SPEED)

(a) When ~~DHS or~~ the ~~Administrative Agent~~ ADvantage Administration (AA) determines that a person requires ADvantage services to begin immediately to prevent nursing facility admission or to ensure the person's health or safety and the UCAT, Part I documents that the person is expected to be eligible for ADvantage, either the ~~DHS~~ OKDHS ~~LTC~~ nurse or the AA will complete the assessment for medical eligibility determination. The completed assessment forms are submitted to the area nurse who makes the medical eligibility decision, enters it on the system and notifies the AA of the decision.

(b) If the applicant fails to meet financial eligibility, providers follow special procedures specified by the AA to bill for services provided. If authorized by the AA, case management providers may bill using an administrative case management procedure code for SPEED services delivered and not reimbursable under any other ADvantage case management procedure code.

317:35-17-18. ADvantage services during hospitalization or NF placement

If a ~~client~~ member requires hospital or nursing facility services, the case manager assists the ~~client is~~ member in accessing institutional care, periodically monitors the ~~client's~~ member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the ~~client~~ member is discharged from the institution and returns home. All case management units for "institution transition" services to plan for and coordinate service delivery and to assist the ~~client~~ member to safely return home, even if provided while the person is in an institution, are to be considered delivered on and billed for the date the ~~client~~ member returns home from institutional care. When the case manager is informed (by the ~~client~~ member, family or service provider) of a ~~client's~~ member's hospitalization or placement in an NF, the case manager determines the date of the ~~client's~~ member's institutionalization and communicates the date, name of institution, reason for placement and expected duration of placement to the ~~Administrative Agent~~ ADvantage Administration (AA) and the ~~client's social~~ member's OKDHS worker.

(1) **Hospital discharge.** When the ~~client~~ member returns home from a hospital or when notified of the ~~client's~~ member's anticipated discharge date, the case manager notifies relevant providers and the AA and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the ~~client~~ member returns home from a NF stay of 30 days or less or when notified of the ~~client's~~ member's anticipated discharge date the case manager notifies relevant providers, the ~~client's social~~ member's OKDHS worker and the AA of the discharge and coordinates the resumption of ADvantage services in the home.

(3) **NF placement greater than 30 days.** When the ~~client~~ member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the ~~client's DHS social~~ member's OKDHS worker, ADvantage case manager, or the AA (whoever first receives

notification of the discharge), notifies other ADvantage Program Administrative partners to expedite the restart of ADvantage services for the ~~client~~ member. In these circumstances, the SPEED process may be used to re-establish ADvantage eligibility to coincide with the date of discharge from the NF. The ~~client's~~ member's case manager provides "institution transition" case management services to assist the ~~client~~ member to re-establish him or herself safely in the home.

317:35-17-20. Case transfer between categories [REVOKED]

~~If it becomes necessary to transfer a case from one category to another because of change in age, income, or marital status, a new application is not required. If someone other than the client or guardian signed the original application form and the transfer is to a money payment case, an application with the client's signature is required. The new case is certified retaining the original certification date and redetermination date, using the appropriate code for transfer from the old category and the appropriate effective date which coincides with the closure of the previous case category. Clients, appropriate medical providers and the ADvantage AA are notified of the new case number and category by computer generated notice.~~

317:35-17-21.1. ADvantage and agency Personal Care provider certification

Either Aging Services or the ~~Administrative Agent~~ ADvantage Administration (AA) forwards information on all certified ADvantage and Personal Care agency providers providing services in the specific ~~DHS~~ OKDHS area to the area nurse and OKDHS county director. The provider information includes agency name, address, contact person for ADvantage/Personal Care programs, provider number, a list of ADvantage/Personal Care services the provider is certified to deliver, and other information as needed by ~~DHS~~ OKDHS staff to achieve efficient service delivery. ~~Aging Services and the~~ The AA ~~certify~~ certifies ADvantage case managers and case management supervisors. The AA maintains a master registry of certified ADvantage case management supervisors and case managers. Case manager certifications are based on successful completion of ADvantage case management training and demonstration of competency in case management and, for supervisors, case management supervision. As additional providers are certified in ~~a DHS~~ an OKDHS area or if a provider loses certification, Aging Services or the AA provides appropriate notice to the area nurse and OKDHS county director in counties affected by the certification changes. The OHCA may execute agreements to provide care only with qualified individuals and agencies and facilities which are properly licensed or certified by the state licensing or certification agency and, as applicable, Title XIX certified. The agreement is initiated by application from the individual agency or facility. The agreement expires on a specified date, with termination of the agency license or certification, or automatically terminated on notice, with appropriate documentation, to OHCA that the individual agency or facility is not in compliance with Title XIX (or other federal long-term care) requirements. The AA certifies Title XIX providers of ADvantage services with the exception of pharmacy and medical equipment and supply providers.

[OAR Docket #10-778; filed 5-7-10]

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

[OAR Docket #10-796]

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RULES:
Subchapter 5. Member Services
Part 1. Agency Companion Services
317:40-5-3. [AMENDED]
317:40-5-8. [AMENDED]
317:40-5-11. [AMENDED]
Part 5. Specialized Foster Care
317:40-5-64. [AMENDED]
Part 9. Service Provisions
317:40-5-101. [AMENDED]
317:40-5-102. [AMENDED]
317:40-5-104. [AMENDED]
317:40-5-110. [AMENDED]
317:40-5-111. [AMENDED]
317:40-5-113. [AMENDED]
Part 11. Other Community Residential Supports
317:40-5-150. [AMENDED]
317:40-5-152. [AMENDED]
317:40-5-153. [AMENDED]
Subchapter 7. Employment Services Through Home and Community-Based Services Waivers
317:40-7-12. [AMENDED]
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Agency rules are revised to clarify levels of support, outside employment guidelines and termination guidelines for Agency Companion Services; specify a review and approval process for Habilitation Training Services (HTS) and clarify proper utilization of HTS; clarify termination of foster providers; clarify the process for provision of nutritional services; clarify requirements for architectural modifications; clarify services and provider requirements relative to specialized medical equipment; clarify responsibilities of Adult Day Services and Daily Living Supports providers; clarify member eligibility for residence in a group home; clarify the process for documenting the need for an enhanced rate in an employment setting; and revise policy to limit state dollar reimbursement for absence of a member receiving Waiver services to not exceed 10% of the authorized units for employment services.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 5. MEMBER SERVICES

PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services

(a) Agency companion services (ACS):

(1) are provided by agencies ~~contracted~~ that have a provider agreement with the Oklahoma Health Care Authority (OHCA);

(2) provide a living arrangement developed to meet the specific needs of the member that includes a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(3) are available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under the age of 18 years may be served with approval from the DDSD director or designee;

(4) are based on the member's need for residential services per OAC 340:100-5-22 and support as described in the member's Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:

(1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD);

(2) may provide companion services for one member. Exceptions to serve as companion for two members may be granted only upon approved by the DDSD director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;

(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the DDSD director or designee;

(4) may not provide companion services to more than two members at any time;

(5) household may not serve more than three members through any combination of companion or respite services;

(6) 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.

(A) Employment as an agency companion is the companion's primary employment.

(B) The companion may not have other employment when~~:~~

~~(i) the member(s) require enhanced or pervasive level of support;~~

~~(ii)~~ approved to serve two members regardless of the levels of support required by the members.

(C) The companion may have other employment when:

~~(i) the member requires intermittent or close levels of support;~~

(~~ii~~ i) the personal support Team documents and addresses all related concerns in the member's IP; ~~and~~

(~~iii~~ ii) the other employment is approved in advance by the DDSD area manager or designee; and

(iii) the companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

(iv) the companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.

~~(7) approved for other employment may not be employed in another position that requires on-call duties.~~

(~~A~~ D) 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~~ E) Homemaker, habilitation training specialist, and respite services are not provided in order for the companion to perform other employment.

(c) Each 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 SoonerCare payment made to the contract provider to enable the member to retain services; and

(B) is claimed when:

(i) the member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless of whether the companion is present; or

(ii) the companion uses authorized respite time;

(C) 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.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate which is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the salary that he or she would earn if the member were not on therapeutic leave.

(d) Levels of support for the member and corresponding payment are:

(1) determined by authorized DDSD staff in accordance with levels described in (A) through(D); and

(2) re-evaluated when the member has a change in agency companion providers which includes a change in agencies or individual companion providers.

(A) **Intermittent level of support.** Intermittent level of support is authorized when the member:

(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

~~(ii) communicates needs and wants;~~

(~~iii~~ ii) ~~is~~ may be able to spend short periods of time unsupervised inside and outside the home; and

(~~iv~~iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities~~; and~~.

~~(v) has stable or no ongoing medical or behavioral difficulties.~~

(B) **Close level of support.** Close level of support is authorized when the member:

(i) requires regular, frequent and sometimes constant physical assistance and support ~~or is totally dependent on others~~ to complete daily living skills, such as bathing, dressing, eating, and toileting;

~~(ii) has difficulty or is unable to communicate basic needs and wants;~~

(~~iii~~ ii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and

(~~iv~~ iii) requires ~~regular monitoring and~~ assistance with health, medication, or behavior interventions~~, and~~ that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is 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, and arranging transportation or other activities;

(ii) demonstrates ongoing complex medical ~~or behavioral~~ issues requiring specialized training courses per ~~OAC 340:100-3-38.3; and~~ OAC 340:100-5-26; or

~~(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 DDSD director or designee; or~~

(~~iv~~ iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14;

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, ~~and~~ or

(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system. The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

317:40-5-8. Agency companion services service authorization budget

Upon approval of the home profile per OAC 317:40-5-40, the companion, provider agency, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case manager, agency companion services (ACS) staff, and others as appropriate meet to develop a service authorization budget. ~~OKDHS Form 06AC074E,~~ The ~~Service Authorization Budget,~~ service authorization budget form is used to develop the individual service budget for the member's program and is updated annually by the member's Personal Support Team (Team).

(1) The companion receives:

(A) a salary based on the level of support needed by the member. The level of support is determined by authorized DDSD staff per OAC 317:40-5-3. The ACS rate for the:

(i) employer model includes funding for the provider agency for the provision of benefits to the companion; and

(ii) contractor model does not include funding for the provider agency for the provision of benefits to the companion; and

(B) any combination of hourly or daily respite per Plan of Care year to equal 660 hours in order to provide respite to the companion as reflected on ~~Form 06AC074E~~ the service authorization budget form.

(~~i~~C) Habilitation training specialist (HTS) services:

(i) may be approved by the DDSD director or designee ~~if~~ when providing ACS with additional support represents the most cost-effective placement for the member and the member has an ongoing pattern of not:

(I) sleeping at night; or

(II) working or attending employment services, ~~in spite of~~ with documented and continuing efforts by the Team.

~~(ii) HTS units authorized must be reduced when the on-going situation changes.~~

(ii) may be approved when a time limited situation exists in which the ACS provider is unable to provide ACS and the provision of HTS will maintain the placement or provide needed stability to the member; and must be reduced when the situation changes.

(iii) ~~HTS authorizations~~ must be reviewed annually or more often if needed, which includes a change in agencies or individual companion providers.

(2) ~~OKDHS Form 6AC074E~~ The service authorization budget form reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the increase must be:

(A) agreed to by the member and, if applicable, legal guardian;

(B) recommended by the Team; and

(C) submitted with written justification attached to ~~OKDHS Form 06AC074E~~ the service authorization budget form to the DDSD area manager or designee for approval.

(3) ~~Prior to the meeting to discuss the service authorization budget, a~~ A back-up plan identifying respite staff is developed by the provider agency program coordination staff and companion, prior to the meeting to discuss the service authorization budget.

(A) The back-up plan:

(i) is submitted to the DDSD case manager for approval and attached to the completed ~~OKDHS Form 06AC074E~~ service authorization form;

(ii) describes expected and emergency back-up support and program monitoring for the home; and

(iii) is signed by the companion, provider agency representative, and DDSD case manager.

(B) The companion and provider agency program coordination staff equally share the responsibility to identify approved respite providers who are:

(i) knowledgeable about the member;

(ii) trained to implement the member's Individual Plan (Plan);

(iii) trained per OAC 340:100-3-38; and

(iv) involved in the member's daily life.

(C) The spouse or other adult residing in the home may provide ACS in the absence of the companion, ~~if~~ when trained ~~in accordance with~~ per OAC 340:100-3-38. ~~The spouse or other adult residing in the home cannot:~~

~~(i) serve as paid respite staff; and~~

~~(ii) be paid simultaneously with the companion.~~

(D) The spouse or other adult residing in the home cannot serve as paid respite staff.

(~~D~~4) The companion and respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.

(~~4~~5) The member is allowed therapeutic leave ~~in accordance with~~ per OAC 317:40-5-3.

317:40-5-11. Termination of Agency Companion ~~services~~ placement

(a) Designated Developmental Disabilities Services Division (DDSD) staff may terminate an individual agency

companion (AC) placement for reasons including, but not limited to:

(1) the ~~service recipient's~~ member's decision to move to a different residence~~. A Team meeting is held to develop an orderly transition plan~~;

(2) the request of the companion~~. A Team meeting is held to develop an orderly transition plan~~;

(3) the Team determines the AC placement is no longer the most appropriate placement for the member;

(~~3~~4) failure of the companion to complete tasks related to problem resolution, ~~as described in~~ per OAC 340:100-3-27, as agreed;

(~~4~~5) confirmed abuse, neglect, or exploitation of any person;

(~~5~~6) breach of confidentiality;

(~~6~~7) involvement of the companion in criminal activity, or criminal activity in the home;

(~~7~~8) failure to provide for the care and well-being of the ~~service recipient~~ member;

(~~8~~9) continued failure to implement the Individual Plan, ~~as described in~~ per OAC 340:100-5-50 through 100-5-58;

(~~9~~10) failure to complete and maintain training ~~as described in~~ per OAC 340:10-3-38;

(~~10~~11) failure to report changes in the household ~~resulting in the failure of the home to meet standards given in OAC 317:40-5-40~~;

(12) failure or inability of the home to meet standards per OAC 317:40-5-40;

(~~11~~13) continued failure to follow applicable Oklahoma Department of Human Services or Oklahoma Health Care Authority rules;

(~~12~~14) decline of the companion's health to the point that he or she can no longer meet the needs of the ~~service recipient~~ member;

(~~13~~15) employment by the companion without prior approval by the DDSD area programs manager for residential services; or

(~~14~~16) domestic disputes which may result in emotional instability of the ~~person receiving services~~ member.

(~~c~~b) Upon termination of the placement~~,~~:

(1) the property of the ~~service recipient~~ member or the state is removed immediately by the ~~service recipient~~ member or his or her designee~~.~~; and

(2) the Team meets to develop an orderly transition plan.

(c) If an individual placement is terminated for reasons identified in (4)-(16) in this Section, DDSD staff will disapprove continued use of the companion.

PART 5. SPECIALIZED FOSTER CARE

317:40-5-64. ~~Closure~~ Termination of a Specialized Foster Care ~~home~~ Provider

(a) In the event that a provider fails to provide services as required by rules or contract, Developmental Disabilities Services Division (DDSD) ~~may, upon written notice to the provider, cancel certification of the home, effective upon receipt of notice~~ notifies the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) Contracts Unit, to terminate the Specialized Foster Care (SFC) provider's contract. Such ~~cancellation~~ termination is not an exclusive remedy but is in addition to any other rights and remedies provided by law.

(b) Possible reasons for ~~closure~~ termination of a ~~Specialized Foster Care (SFC) home~~ provider include, but are not limited to:

(1) provider request;

(2) non-cooperation in determining compliance with standards, policy, or contract;

(3) confirmed abuse, neglect, or exploitation of any other person;

(4) breach of confidentiality;

(5) involvement in criminal activity or criminal activity in the home;

(6) failure to provide for the care and well-being of the ~~service recipient~~ member;

(7) continued failure to implement the ~~service recipient's~~ member's Plan;

(8) failure to complete and maintain required provider training;

(9) failure to report changes in the household ~~resulting in the failure of the home to meet standards~~;

(10) continued failure to follow ~~DDSD~~ OKDHS or OHCA ~~policy~~ rules;

(11) decline of the provider's health to the point that he or she can no longer meet the needs of the ~~service recipient~~ member;

(12) employment by the provider without prior approval by the ~~Developmental Disabilities Services Division (DDSD) SFC supervisor~~ area program manager for residential services;

(13) domestic disputes that may result in emotional instability of the ~~service recipient~~ member; ~~or~~

(14) failure to complete a ~~Plan of Action~~ plan of action, ~~as described in~~ per OAC 317:40-5-63, as agreed~~.~~; or

(15) failure or inability of the home to meet standards per OAC 317:40-5-40.

(c) **~~Closure~~ Termination Process.** When necessary to ~~close an~~ terminate a SFC ~~home~~ provider, the steps described in this Subsection are taken.

(1) ~~SFC~~ DDSD staff documents~~,~~ in the provider case narrative, a summary of the reasons for ~~closure~~ termination and the effective date ~~of the closure~~.

(2) The DDSD ~~Area Manager~~ area manager or designee notifies the case manager and case manager supervisor to ~~make~~ notify legally responsible person(s) and identify other living arrangements, if applicable, for the ~~service recipient~~ member.

(3) The DDSD programs manager for residential services sends a 30-day written notice of the ~~closure~~ termination to the provider.

(A) A copy of the 30-day notice is sent to:

(i) the case manager;

(ii) case management supervisor;

(iii) DDSD ~~Area Manager~~ area manager;

(iv) DDSD State Office; and

(v) ~~Division of Children and Family Services (DCFS)~~Children and Family Services Division (CFSD), if applicable.

(B) A copy of the narrative is sent with the written notice to DDSD State Office;

(4) DDSD State Office notifies the ~~Oklahoma Health Care Authority~~ OHCA and the OKDHS Contracts Unit to ~~close~~ terminate the provider's contract.

PART 9. SERVICE PROVISIONS

317:40-5-101. Architectural modifications

(a) **Applicability.** The rules in this Section apply to architectural modification (AM) services authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(~~a~~ b) **General information.** Architectural ~~modifications are performed by providers who have contractual agreements with the Oklahoma Health Care Authority to provide Home and Community Based Services (HCBS) to the home of an eligible member with accessibility, behavioral, sensory, or environmental difficulties to enhance the member's independence and safety.~~ Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC), formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;

(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities, specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;

(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;

(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;

(~~1~~5) ~~Architectural modifications~~ are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;

(D) ~~availability~~ lack of a less expensive equivalent, such as assistive technology, that meets the member's needs~~.~~ ; and

(E) safety and suitability of the home.

(~~2~~6) ~~Necessary architectural~~ are limited to modifications ~~may be provided for each member for no more than~~ of two different residences within any ~~five~~ seven year period beginning with the member's first request for an approved architectural modification service~~.~~;

(7) are provided with assurance of plans for the member to remain in the residence for at least five years;

(~~3~~ 8) ~~The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD)~~ may be ~~deny~~ denied ~~authorization for architectural modifications services to the home of a member~~ when DDSD determines the home is unsafe or otherwise unsuitable for architectural modifications.

(A) DDSD area office resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.

(B) Members needing home modification services and provider agencies assisting members to locate rental property ~~recommend~~ identify several homes, when possible, for screening in order ~~that~~ to select a home with ~~minimal~~ the fewest or most cost effective modifications ~~may be selected.~~;

(~~4~~9) ~~Architectural modifications~~ are provided~~,~~ to eligible members with the homeowner's signed permission~~, to eligible members whether the member's home is rented or owned.~~;

~~(5) Only modifications that are specific to the member's unique needs are authorized.~~

(~~6~~10) ~~Architectural modifications~~ are not ~~used~~ authorized to modify homes solely for family or staff convenience or for cosmetic preference~~.~~;

(~~7~~11) ~~Modifications~~ are provided on finished rooms complete with wiring and plumbing~~.~~;

(~~8~~12) ~~The DDSD director or designee may approve written requests for exceptions to requirements of OAC 317:40-5-1-1 in exceptional circumstances.~~ services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDSD division administrator or designee in exceptional circumstances; and

(~~9~~13) ~~Authorization of architectural modifications complies~~ are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., §85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

(~~b~~ c) **Assessment and Team process.**

(1) Architectural modification assessments are performed by:

(A) DDSD area office resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or

(B) a licensed occupational therapist or physical therapist, at the request of designated DDSD area office resource development staff or area program supervisory staff, when the requested architectural modification ~~does not comply~~ exceeds or requires a variance to applicable national standards for persons with physical disabilities, ~~as applicable to private homes~~ or when such expertise is deemed necessary by DDSD area office resource development staff or area program supervisory staff.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's ~~present~~ needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) ~~are needed by the member to achieve an activity that is:~~ are necessary to ensure the health, welfare, and safety of the member; and

~~(i) meaningful to the member and requires another person to perform the activity, if the member cannot perform the activity independently, such as self-care, eating, or transfers; and~~

~~(ii) age-appropriate, considering the member's level of functioning; and~~

(B) ~~enhance the member's ability to:~~ provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

~~(i) improve or maintain health and safety;~~

~~(ii) participate in community life;~~

~~(iii) establish meaningful relationships;~~

~~(iv) express choices; or~~

~~(v) live with dignity.~~

(~~c~~ d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed; ~~and~~

(B) following all applicable building codes~~.~~ ; and

(C) taking and providing pictures to area office resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. Area office resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;

(B) vehicle insurance; and

(C) worker's compensation insurance or affidavit of exemption.

~~(d) **Standards for construction of architectural modifications.** All modifications are made in accordance with local and state housing codes, and permits are the sole responsibility of the contractor.~~

(~~1~~ 5) All modifications meet ~~the applicable~~ national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

(~~2~~ 6) Contractors complete construction in compliance with written assessment recommendations ~~and addenda~~ from the:

(A) DDSD area office resource development staff with architectural modification experience~~, when the requested architectural modification complies with applicable national standards for persons with physical disabilities as applicable to private homes~~; or

(B) a licensed professional.

(~~3~~ 7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

(~~4~~ 8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) All exterior wooden ramps are constructed of number two pressure treated wood.

(B) Surface of the ramp has a rough, non-skid texture.

(C) Ramps are assembled by the use of deck screws.

(D) Hand rails on ramps, if required, are sanded and smooth.

(E) Ramps can be constructed of stamped steel.

(F) Support legs on ramps are no more than six feet apart.

(G) Posts on ramps must be set or anchored in concrete.

(~~5~~ 9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that ~~is sloped at least two inches from the outside walls down to the drain, when space permits. When space does not permit, the floor slopes as much as is possible and appropriate~~ slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 ~~to 36~~ inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

(~~6~~ 10) DDSD area office resource development staff ~~inspects~~ inspect any or all architectural modification work ~~and takes pictures of the final project~~, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that ~~was~~ has been ~~architecturally~~ modified ~~using state or HCBS Waiver funds,~~ and the member will no longer be sharing the home, the member whose Plan of Care ~~includes~~ authorized the modifications is given the first option of remaining in the residence ~~if the roommates no longer wish to share a home~~.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class~~,~~ when a written agreement between the homeowner and DDSD director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDSD director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** ~~Architectural modification services make homes accessible according to the member's specific needs.~~ Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) ~~No square~~ Square footage is not added to the home as part of ~~the~~ an architectural modification ~~process~~.

(2) ~~The OKDHS does not authorize payment or provide any architectural modification~~ Architectural modifications are not performed during construction or remodeling of a home ~~that is owned or being built for the member or his or her family~~.

(3) Modifications ~~that are~~ not ~~considered architectural modifications and cannot be~~ authorized by the OKDHS include, but are not limited to:

(A) roofs;

(B) installation of heating or air conditioning units;

(C) humidifiers;

(D) water softener units;

(E) fences;

(F) sun rooms;

(G) porches;

(H) decks;

(I) canopies;

(J) covered walkways;

(K) driveways;

(L) sewer lateral lines or septic tanks;

(M) foundation work;

(N) room additions;

(O) carports;

(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;

(Q) non-adapted home appliances;

(R) carpet or floor covering~~, unless documented as necessary to aid the member in mobility; and~~ that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or

(S) ~~walk in bathtubs~~ a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless~~:~~ needed by the member to move between the house and vehicle.

~~(A) needed by the member to move between the house and behicle; and~~

~~(B) AUTHORIZED BY THE ddsd DIRECTOR OR DESIGNEE. The DDSD director or designee may consaider other sidewalk needs.~~

(g) **Approval or denial of architectural modification ~~requests~~ services.** DDSD approval or denial of ~~the~~ an architectural modification ~~request~~ service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request ~~sent~~ provided by the DDSD case manager to DDSD area office resource development staff includes:

(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;

(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101~~(b)~~; ~~and~~

(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months~~.~~ ; and

(D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) ~~Prior to authorization of architectural modification services, at least three competitive bids are obtained for services costing $750 or more.~~ The DDSD area office:

(A) authorizes architectural modification services ~~up to~~ less than $2500~~;~~ when the plan of care is less than the state office reviewer limit; and

~~(B) is responsible for all required documentation; and~~

(~~C~~ B) ~~sends~~ provides all ~~necessary~~ required information to the DDSD State Office architectural modification programs manager for authorization of

services ~~costing~~ when the plan of care is more than the area office limit or is $2500 or more.

(3) ~~If the DDSD area office resource development staff, therapist, or Team determines the service is not appropriate, the DDSD area office resource development staff or DDSD State Office Programs manager for architectural~~ Architectural modifications ~~provides a brief report describing the reason for the denial to the DDSD case manager~~ may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals.** The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

317:40-5-102. Nutrition Services

(a) ~~**Purpose**~~ **Applicability.** The rules in this Section ~~are established to ensure that~~ apply to nutrition services authorized for members ~~to sustain quality of life and ensure optimal nutritional status are provided to individuals with developmental disabilities~~ who receive services through Home and Community-Based Services (HCBS) ~~Waiver services~~ Waivers operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD).

(b) **General information.** Nutrition services include nutritional evaluation and consultation to members and their caregivers, are intended to maximize the member's health and are provided in any community setting as specified in the member's Individual Plan (IP). Nutrition services must be prior authorized, included in the member's Individual Plan (IP) and arrangements for this service must be made through the member's case manager. Nutrition service contract providers must be licensed in the state where they practice and registered as a dietitian with the Commission of Dietetic Registration. Each dietitian must have a current provider agreement with the Oklahoma Health Care Authority (OHCA) to provide Home and Community Based Services, and a SoonerCare provider agreement for nutrition services. Nutrition Services are ~~based on the individual's need~~ provided per Oklahoma Administrative Code (OAC) 340:100-3-33.1. ~~as specified by the Individual Plan and include evaluation of the service recipient's nutritional status.~~ In order for the member to receive Waiver-funded nutrition services, the requirements in this Section must be fulfilled.

~~(1) If nutrition services from funding sources other than Waiver services are available to the service recipient, the service recipient uses those services before using Waiver services. In order for the service recipient to receive Waiver funded nutrition services, the requirements in this Section must be fulfilled.~~

~~(2) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services.~~

~~(A) Refusal of nutrition services must be documented in the Individual Plan.~~

~~(B) If the service recipient has been receiving nutrition services and nutritional status is currently stable, the Team may specify that nutrition services are not needed. The Team specifies individual risk factors for the service recipient that would necessitate resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the service recipient's status regarding these factors.~~

~~(3) Staff of the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) and contract agents implement procedures for nutritional risk identification, implementation of needed services, and nutritional risk monitoring to maintain and improve the nutritional health status of each person served.~~

(1) The member must be assessed by the case manager to have a possible eating problem or nutritional risk.

(2) The member must have a physician's order for nutrition services current within one year.

(3) Per OAC 340:100-5-50 through 58, the team identifies and addresses member needs.

(4) Nutrition services may include evaluation, planning, consultation, training and monitoring.

(5) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services per OAC 340:100-3-11. Refusal of nutrition services must be documented in the Individual Plan.

(6) A minimum of 15 minutes for encounter and record documentation is required.

(7) A unit is 15 minutes.

(8) Nutrition services are limited to 192 units per Plan of Care year.

~~(c) **Services for persons not receiving residential supports.** If the service recipient does not receive residential supports as defined in OAC 340:100-5-22.1, or group home services:~~

~~(1) the Individual Plan must justify the need for nutrition services as described in OAC 340:100-3-33.1, Criteria to establish service necessity; and~~

~~(2) procedures described in subsections (e) through (j) are followed unless other procedures are approved in writing by the DDSD area manager or designee.~~

~~(d) **Services for persons receiving residential supports.** If the service recipient receives residential supports as defined in OAC 340:100-5-22.1, or group home services:~~

~~(1) the service recipient must have an updated OKDHS Form DDS-7, Physical Status Review (PSR), in accordance with OAC 340:100-5-26, identifying an eating problem or nutritional risk. indicated by a score of 3 or 4 on Eating, 4 on Gastrointestinal, 4 on Skin Breakdown, 4 on bowel Function, or 3 or 4 on the Nutrition section of the PSR. The Team must address these risks in the Individual Plan and identify appropriate professional oversight; and~~

~~(2) the requirements in subsections (e) through (j) of this Section are followed.~~

(~~e~~c) ~~**Assessment**~~ **Evaluation.** When arranged by the case manager, the ~~The~~ nutrition ~~therapist~~ services contract provider evaluates the member's ~~service recipient's~~ nutritional status and completes the ~~OKDHS Form DDS-40,~~ Level of Nutritional Risk Assessment.

(1) The evaluation ~~assessment~~ must include, but is not limited to:

(A) health, diet, and behavioral history impacting on nutrition;

(B) clinical measures including body composition and physical assessment.

(C) dietary assessment, including:

(i) nutrient needs;

(ii) eating skills;

(iii) nutritional intake; and

(iv) drug-nutrient interactions; and

(D) recommendations to address nutritional risk needs, including:

(i) outcomes;

(ii) strategies;

(iii) staff training; and

(iv) program monitoring and evaluation.

(2) The nutrition services contract provider ~~therapist~~ and other involved professionals make recommendations for achieving positive nutritional outcomes based on the risks identified on the OKDHS Level of Nutritional Risk Assessment. ~~form DDS-40.~~

(3) The nutrition services contract provider ~~therapist~~ sends a copy of the Level of Nutritional Risk Assessment ~~DDS-40~~ to the case manager within ten working days of receipt of the authorization.

(4) If the ~~assessment~~ evaluation shows the member ~~service recipient~~ rated as "High Nutritional Risk", the nutrition services contract provider ~~therapist~~ sends a copy of the Level of Nutritional Risk Assessment ~~DDS-40~~ to the DDSD area nutrition therapist or DDSD area professional support services designee as well as the case manager within 10 working days of receipt of the authorization.

(~~f~~d) **Planning.** The DDSD case manager, in conjunction with the Team, reviews the identified nutritional ~~issues~~ risks that impact the member's ~~service recipient's~~ life.

(1) Desired nutritional outcomes are developed and integrated into the Individual Plan using the least restrictive, least intrusive, most normalizing measures that can be carried out across environments.

(2) The Team member(s) identified responsible in the Individual Plan develops methods to support the nutritional outcomes, which may include:

(A) Stragegies;

(B) Staff training; or

(C) Program monitoring.

(3) When the member has been receiving nutrition services and nutritional status is currently stable and the Team specifies that nutrition services are no longer needed, the Team will identify individual risk factors for the member that would indicate consideration of the resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the members status regarding these factors.

(~~1~~4) Any ~~service recipient with a PSR score of 3 or above on Section A, Eating,~~ member who receives paid 24 hour per day supports and requires constant physical assistance and mealtime intervention to eat safely, or is identified for risk of choking or aspiration must have an individualized mealtime assistance plan developed and reviewed at least annually by the Team member(s) identified responsible in the Individual Plan. Team members may include a nutrition services contract provider and a speech therapy contract provider or occupational therapy contract provider with swallowing expertise (mealtime therapists). Documentation should delineate responsibilities to insure there is no duplication of services. The mealtime assistance plan includes but is not limited to:

(A) a physician ordered diet ~~or meal plan~~;

(B) diet instructions;

(~~B~~C) positioning needs;

(~~C~~D) ~~adaptive equipment~~ assistive technology needs;

(~~D~~E) communication needs;

(F) eating assistance techniques;

(G) supervision requirements;

~~(E) food presentation;~~

(~~F~~H) documentation requirements;

(~~G~~I) monitoring requirements; and

(~~H~~J) training and assistance ~~requirements~~.

~~(2) In accordance with OAC 340:100-5-26, the Team:~~

~~(A) discusses any gastrostomy or jejunostomy tube placement, including discussion of less intrusive alternatives, prior to implementation of the proposed procedure; or~~

~~(B) reviews emergency placement of any gastrostomy or jejunostomy tube within five working days after placement.~~

(5) For those members receiving paid 24 hour per day supports and nutrition through a feeding tube, the Team develops and implements strategies for tube feeding administration that enables members to receive nutrition in the safest manner and for oral care that enables optimal oral hygiene and oral-motor integrity as deemed possible per OAC 340:100-5-26. The Team reviews the member's ability to return to oral intake following feeding tube placement and annually thereafter in accordance with the member's needs.

~~(3) The Team annually develops, and documents in the Individual Plan a review of, a plan for return to oral intake, in accordance with individual needs, for each service recipient who receives nutrition through a tube.~~

~~(4) Desired nutritional outcomes are developed and integrated into the Individual Plan using the least restrictive, least intrusive, most normalizing measures that can be carried out across environments.~~

~~(5) The Team member(s) identified responsible in the Individual Plan develops methods to support the nutritional outcomes, which include:~~

~~(A) implementation strategies;~~

~~(B) staff training; and~~

~~(C) program monitoring.~~

(~~g~~e) **Implementation, Consultation and Training.** Strategies are implemented by the assigned person within a designated time frame established by the Team based on individual need(s).

(1) Direct support staff members are trained ~~in accordance with~~ per the Individual Plan and OAC 340:100-3-38.

(2) All special diets, nutritional supplements, and aids to digestion and elimination must be prescribed and reviewed at least annually by a physician.

(3) Consultation to members and their caregivers is provided as specified in the IP.

(~~h~~4) ~~**Documentation.**~~ Program documentation ~~as determined necessary by the Team~~ is maintained in the ~~service recipient's~~ member's home record for the purpose of evaluation and monitoring. ~~The professional provider(s) sends documentation regarding the service recipient's progress on the nutrition outcomes, program concerns, and recommendations for remediation of any problem area to the case manager each month, or as often as deemed necessary by the Team.~~

(5) The contract professional provider(s) sends documentation regarding the member's program concerns, recommendations for remediation of any problem area and progress notes to the case manager per OAC 340:100-5-52.

~~(i) **Evaluation and monitoring.** A review to evaluate the success of the program is performed at least once each month or as deemed necessary in the Individual Plan by the professional(s) designated by the Team. The area manager or designee may require a specified schedule for service recipients with a high nutritional risk.~~

(~~1~~A) The designated professional(s) reviews the program data submitted for:

(~~A~~ i) completeness;

(~~B~~ ii) consistency of implementation; and

(~~C~~ iii) positive outcomes.

~~(2) DDSD professional support services personnel provide administrative oversight and quality assurance monitoring on an ongoing basis to service recipients with eating risk or nutritional risk identified through the PSR using:~~

~~(A) on-site visits; and~~

~~(B) record reviews.~~

(~~3~~B) When a ~~service recipient~~ member is identified by the Level of Nutritional Risk Assessment ~~DDS-40~~ to be at high nutritional risk, he or she receives increased monitoring by~~:~~

~~(A)~~ the nutrition services contract provider ~~therapist~~ and health care coordinator, as determined necessary by the Team.~~; and~~

~~(B) the DDSD area nutrition therapist or DDSD area professional support services designee.~~

(~~4~~C) Significant changes in nutritional status must be reported to the case manager by the health care coordinator.

(~~5~~D) The Level of Nutritional Risk Assessment ~~DDS-40~~:

(~~A~~i) is used by the ~~contract~~ nutrition services contract provider to reassess ~~service recipients~~ members at high risk on a quarterly basis; and

(~~B~~ii) must be submitted by the ~~contract~~ nutrition services contract provider to the DDSD area nutrition therapist or DDSD area professional support services designee within 15 days following the end of each quarter ~~(March, June, September, December)~~.

~~(6) The DDSD area nutrition therapist or designee, in conjunction with DDSD support services professionals, provides technical assistance to resolve individual nutrition issues and makes recommendations for additional technical assistance if needed.~~

~~(j) **Technical Assistance.** Professional contract providers serving as management consultants provide technical assistance as authorized. Technical assistance may be requested using OKDHS form DDS-41, Physical-Nutritional Management Consultation Request, by the Team or DDSD support services staff to address:~~

~~(1) unresolved nutritional management issues;~~

~~(2) gastrostomy or jejunostomy tube placement or removal;~~

~~(3) individualized mealtime assistance plan development; or~~

~~(4) any aspect of assessment, planning, implementation, evaluation, or monitoring of nutrition services.~~

317:40-5-104. Specialized medical supplies

(a) **Applicability.** The rules in this section apply to specialized medical supplies provided through Home and Community Based Services (HCBS) Waivers operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD).

(~~a~~b) **General ~~requirements~~ information.** Specialized medical supplies include supplies specified in the plan of care ~~that meet the criteria given in this Section.~~ that enable the member to increase his or her ability to perform activities of daily living. ~~(1)~~ Specialized medical supplies include the purchase of ancillary supplies not available ~~under the Medicaid State Plan~~ through SoonerCare.

(1) Specialized medical supplies must be included in the member's plan and arrangements for this service must be made through the member's case manager. Items reimbursed with Home and Community Based Services ~~(HCBW)~~ (HCBS) funds are in addition to any supplies furnished ~~under the Medicaid State Plan~~ by SoonerCare.

(2) Specialized medical supplies meet the criteria for service necessity given in OAC 340:100-3-33.1.

(3) All items meet applicable standards of manufacture, design, and installation.

(4) Specialized medical supplies providers must hold a current SoonerCare Durable Medical Equipment (DME) and/or Medical Supplies Provider Agreement ~~contract~~ with the Oklahoma Health Care Authority~~.~~, and be registered to do business in Oklahoma or the state in which they are domiciled. Providers must enter into the agreement giving assurance of ability to provide products

and services and agree to the audit and inspection of all records concerning goods and services provided.

(5) Items that can be purchased as specialized medical supplies include:

(A) incontinence supplies, as described in subsection (b) of this Section;

(B) nutritional supplements;

(C) supplies for respirator or ventilator care;

(D) decubitus care supplies;

(E) supplies for catheterization; and

(F) supplies needed for health conditions.

(6) Items that cannot be purchased as specialized medical supplies include:

(A) over the counter medications(s);

(B) personal hygiene items;

(C) medicine cups;

(D) items that are not medically necessary; and

(E) prescription medication(s)~~;~~ . ~~and~~

~~(F) items available through the Medicaid State Plan. Items available through the Medicaid State Plan must be exhausted before waiver-funded services can be accessed.~~

(7) Specialized medical supplies must be:

(A) necessary to address a medical condition;

(B) of direct medical or remedial benefit to the ~~service recipient~~ member;

(C) medical in nature; and

(D) consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

(~~b~~ c) **Limited coverage.** Items available in limited quantities through specialized medical supplies include:

(1) incontinence wipes, 300 wipes per month;

(2) non-sterile gloves, as approved by the Team;

(3) disposable underpads, 60 pads per month; and

(4) incontinence briefs, 180 briefs per month.

(A) Adult briefs are purchased only in accordance with the implementation of elimination guidelines developed by the Team.

(B) Exceptions to the requirement for implementation of elimination guidelines may be approved by the DDSD nurse when the ~~service recipient~~ member has a medical condition that precludes implementation of elimination guidelines, such as atonic bladder, neurogenic bladder, or following a surgical procedure.

(~~c~~ d) **Exceptions.** Exceptions to the requirements of this Section are explained in this subsection.

(1) When a ~~service recipient's~~ member's Team determines that the ~~service recipient~~ member needs medical supplies that:

(A) are not available ~~under the Medicaid State Plan~~ through SoonerCare and for which no Health Care Procedure Code exists, the case manager e-mails pertinent information regarding the ~~service recipient's~~ member's medical supply need to the programs manager responsible for Specialized Medical Supplies. The e-mail includes all pertinent information that supports the need for the supply, including but not limited to, quantity and purpose; or

(B) exceed the limits stated in subsection ~~(b)~~ (c) of this Section, the case manager ~~submits the request for additional supplies to the DDSD area manager~~ documents the need in the Individual Plan for review and approval per 340:100-33.

(2) Approval or denial of exception requests is made on a case by case basis and does not override the general applicability of this Section.

(3) Approval of a specialized medical supplies exception does not exceed one plan of care year.

317:40-5-110. Authorization for Habilitation Training Specialist Services

(a) Habilitation Training Specialist (HTS) Services are:

(1) authorized as a result of needs identified by the team and informed selection by the ~~service recipient~~ SoonerCare member;

(2) shared among ~~service recipients~~ SoonerCare members who are members of the same household or being served in the same community location; ~~and~~

(3) authorized only during periods when staff are engaged in purposeful activity which directly or indirectly benefits the service recipient. Staff must be physically able and mentally alert to carry out the duties of the job. At no time are HTS services authorized for periods during which the staff are allowed to sleep~~.~~ ;

(4) not authorized to be provided in the home of the HTS unless the SoonerCare member and HTS reside in the same home; and

(5) directed toward the development or maintenance of a skill in order to achieve a specifically stated outcome. The service provided is not a function which the parent would provide for the individual without charge as a matter of course in the relationship among members of the nuclear family when the member resides in a family home.

(b) HTS Services may be provided in a group home as defined in 317:40-5-152 or community residential service settings defined in OAC 340:100-5-22.1 including:

(1) agency companion services as described in OAC 317:40-5-1 through 40-5-39;

(2) as provided in accordance with Daily Living Supports policy at OAC 317:40-5-150; and,

(3) as provided in accordance with Specialized Foster Care Policy at OAC 317:40-5-50 through 40-5-76; or

(4) services for people with Prader Willi syndrome.

(c) HTS Services are based on need and limited to no more than 12 hours per day per household in any setting other than settings described in OAC 340:100-5-22.1, Community Residential Supports, except with approval in accordance with OAC 340:100-3-33, Service authorization, that the increased services are necessary to avoid institutional placement due to:

(1) the complexity of the family or caregiver support needs. Consideration must be given to:

(A) the age and health of the caregiver;

(B) the number of household members requiring the caregiver's time; and

(C) the accessibility of needed resources; and

(2) the resources of the family, caregiver, or household members that are available to the service recipient. Consideration must be given to the number of family members able to assist the caregiver and available community supports; and

(3) the resources of other agencies or programs available to the ~~service recipient~~ SoonerCare member or family. Consideration must be given to services available from:

(A) the public schools;

(B) the Oklahoma Health Care Authority;

(C) the Oklahoma Department of Rehabilitative Services;

(D) other OKDHS programs; and

(E) services provided by other local, state, or federal resources.

(d) When it appears that approval of an exception is needed to prevent institutional placement, the case manager submits the request which identifies the circumstances supporting the need for an exception to the area manager.

(e) The DDSD area manager or designee must approve, deny, or notify the case manager of issues preventing approval within 10 working days.

(f) HTS providers may not perform any job duties associated with other employment, including on call duties, at the same time they are providing HTS services.

(g) HTS services are limited to no more than 40 hours per week when the HTS resides in the same home as the service recipient. If additional hours of service are needed, they must be provided by someone living outside the home.

(h) When the member is out of the home for school, work, adult day services or other non-HTS supported activities, the total number of hours of HTS and hours away from the home cannot exceed 12 hours per day unless an exception is granted in accordance with subsection c of this policy.

(i) In accordance with OAC 340:100-3-33.1, services must be provided in the most cost effective manner. When the need for HTS services is expected to continue to exceed 9 hours daily, cost effective community residential services must be considered and requested in accordance with OAC 317:40-1-2. For adults, continuation of non-residential services in excess of 9 hours per day for more than one plan of care year will not be authorized except:

(1) when needed for members who receive services through the Homeward Bound Waiver;

(2) when determined by the division administrator or designee to be the most cost effective option; or

(3) as a transition period of 120 days or less to allow for identification of and transition to a cost effective residential option. Members who do not wish to receive residential services will be assisted to identify options that meet their needs within an average of 9 hours daily.

317:40-5-111. Authorization for Habilitation Training Specialist Services in the Homeward Bound Waiver

(a) Habilitation Training Specialist (HTS) Services are authorized as a result of needs identified by the Personal Support Team and informed service recipient selection.

(b) HTS Services may be provided in the Homeward Bound waiver in service settings including:

(1) agency companion services as described in OAC 317:40-5-1 through OAC 317:40-5-39;

(2) daily living supports as described in OAC 317:40-5-153;

(3) specialized foster care as described in OAC 317:40-5-50 through OAC 317:40-5-76;

(4) group home services as described in OAC ~~340:100-6~~ 317:40-5-152; and

(5) the class member's own home, family's home, or other community residential setting.

(c) HTS services are authorized only during periods when staff are engaged in purposeful activity that directly or indirectly benefits the person receiving services.

(1) Staff must be physically able and mentally alert to carry out the duties of the job.

(2) At no time are HTS services authorized for periods during which the staff are allowed to sleep.

317:40-5-113. Adult Day Services

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care Authority contract for providing Adult Day Services. This service is available through the Community Waiver and through the In-Home Supports Waiver for Adults. 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. Individuals who participate in adult day services receive these services on a planned basis during specified hours. Adult day services are designed to work toward the goals of:

(1) promoting the ~~individual's~~ member's maximum level of independence;

(2) maintaining the ~~individual's~~ member's present level of functioning as long as possible, preventing or delaying further deterioration;

(3) assisting the ~~individual~~ member in achieving the highest level of functioning possible;

(4) providing support, respite, and education for families and other caregivers; and

(5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible ~~service recipients~~ members whose teams have determined the service is appropriate to meet their needs. ~~Service recipients~~ Members must:

(1) require ongoing support and supervision in a safe environment when away from their own residence;

(2) be 18 years of age or older; and

(3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:

(1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;

(2) comply with OAC 310:605, Adult Day Care Centers;

(3) allow DDSD staff to make announced ~~or~~ and unannounced visits to the facility during the hours of operation;

(4) provide the DDSD ~~Case Manager~~ case manager a copy of the individualized plan of care; ~~and~~

(5) submit incident reports ~~in accordance with~~ per OAC 340:100-3-34~~.~~ ;

(6) maintain a copy of the member's Individual Plan (Plan);

(7) submit Oklahoma Department of Human Services (OKDHS) Adult Day Services Progress Report Form 06WP046E to the DDSD case manager by the tenth of each month for the previous month's services, for each member receiving services; and

(8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The ~~service recipient's~~ member's ~~Individual Plan (IP)~~ Plan contains detailed descriptions of services to be provided and documentation of hours of services. All services must be authorized in the ~~IP~~ Plan and reflected in the approved plan of care. Arrangements for care must be made with the ~~service recipient's~~ member's case manager.

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-150. Daily Living Supports for the Community Waiver

(a) **Introduction.** Daily Living Supports (DLS) are provided by an agency, approved by the Developmental Disabilities Services Division (DDSD), that has a valid Oklahoma Health Care Authority contract for the service.

(1) Daily Living Supports require meeting the daily support needs of the ~~service recipients~~ members living in the home.

(A) In accordance with the needs of the ~~service recipient~~ member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the ~~service recipient~~ member performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports also include assistance with cognitive tasks or provision of services, ~~in accordance with~~ per OAC 340:100-5-57, to prevent a ~~service recipient~~ member from harming self or others.

(C) Daily Living Supports also include:

(i) the provision of staff training ~~in accordance with~~ per OAC 340:100-3-38, to meet the specific needs of the ~~service recipient~~ member;

(ii) program supervision that includes the 24-hour availability of response staff to meet schedules and unpredictable needs;

(iii) program oversight;

(iv) assisting the ~~service recipient~~ member in obtaining services and supplies;

(v) developing and assuring emergency plans are in place; and

(vi) coordinating overall safety and supports in the home.

(D) Direct support services are coordinated and shared among household members receiving services to meet identified needs and are provided by staff who do not live in the home.

(2) DLS include an average of eight hours daily of direct support services. ~~Service recipients~~ Members needing direct support services exceeding an average of eight hours per day identify, with case manager assistance, roommates willing to share Daily Living Supports services. Additional direct support services are considered in accordance with subsection (f) of this Section.

(b) **Eligibility.** Daily Living Supports are provided to ~~individuals~~ members who:

(1) are eighteen years of age or older, unless approved by the Director of OKDHS or designee;

(2) need an average of at least eight hours of direct support services daily;

(3) are participants in the DDSD Community waiver, ~~described in~~ per OAC 317:40-1-1;

(4) need community residential services outside the family home; and

(5) do not simultaneously receive any other community residential or group home services.

(c) **Service requirements.** Daily Living Supports must be:

(1) included in the ~~service recipient's~~ member's Individual Plan ~~in accordance with~~ per OAC 340:100-5-51, including a description of the type(s) and intensity of supervision and assistance that must be provided to the ~~service recipient~~ member;

(2) authorized in the ~~service recipient's~~ member's Plan of Care;

(3) provided by the contracted provider agency chosen by the ~~service recipient~~ member or guardian;

(4) delivered in accordance with DDSD Community Residential Supports rules at OAC 340:100-5-22.1; and

(5) provided directly to the ~~service recipient~~ member.

(d) **Home Requirements.** Daily Living Supports are provided to eligible ~~service recipients~~ members living outside their family's home in a home that:

(1) is leased or owned by the ~~service recipient(s)~~ member(s) or the ~~service recipient's~~ member's legal guardian; and

(2) houses no more than three individuals living together. Exceptions for homes shared by four ~~service recipients~~ members may be granted in writing by the DDSD director or designee.

(e) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

(1) ensure ongoing supports as needed when the ~~service recipient~~ member is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) ensure compliance with all applicable DDSD policy found at OAC 340:100; and

(3) provide for the welfare of all ~~service recipients~~ members living in the home.

(4) ensure that trained staff are available to the member as described in the individual plan.

(f) **Criteria for direct support staff services beyond eight hours per day.** Additional direct support services including Habilitation Training Specialist(HTS), Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section must be approved by the DDSD area manager or designee.

(1) In order to receive additional direct support staff services, the ~~service recipients~~ members living together must have insufficient supports including hourly nursing services to meet their needs for support.

(A) Additional direct support staffing may be authorized if the ~~service recipient~~ member is living with two roommates but still has medical or behavior support needs beyond the capacity of staff shared with the other roommates, including participation by staff providing hourly nursing services.

(B) Additional direct support staffing is only provided to a ~~service recipient~~ member who has one or no roommates if:

(i) the area manager or designee documents that behavior support issues make it impossible for the ~~service recipient~~ member to have a roommate; or

(ii) in accordance with paragraph (2) of this subsection.

(C) If a ~~service recipient~~ member lives with one or no roommates or requires a second support staff to meet his or her intensive behavior support needs, the Team must provide clear documentation that the ~~service recipient~~ member has difficulty establishing compatible relations with others as evidenced by:

(i) severe and persistent emotional and behavioral disturbances; or

(ii) a history of difficulty sharing a home with others.

(2) The area manager or designee may grant conditional approvals for staff beyond an average of eight hours per day per ~~service recipient~~ member:

(A) due to the temporary or permanent departure of a roommate while another roommate is being identified; or

(B) to facilitate emergency residential placement of a person needing services while roommates are being identified.

(3) As part of the annual review, the case manager must:

(A) re-evaluate the ~~service recipient's~~ member's additional direct support services; and

(B) implement any alternative solutions that would promote independence and reduce intrusion by paid workers as much as possible. Documentation of such evaluations and the implementation of alternative solutions is included in the case manager's record.

(g) **Daily Living Supports claims.** No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each ~~service recipient~~ member.

(1) The provider agency claims one unit of service for each day during which the ~~service recipient~~ member receives Daily Living Supports. A day is defined as the period between 12:00 a.m. and 11:59 p.m.

(2) Claims must not be based on budgeted amounts.

(3) When a ~~service recipient~~ member changes provider agencies, only the outgoing service provider agency claims for the day that the ~~service recipient~~ member moves.

(h) **Billing for other support services.** Additional support services such as HTS, Intensive Personal Supports, or Homemaker Services may be provided to a ~~service recipient~~ member receiving Daily Living Supports, if:

(1) the additional support services have been authorized in the ~~service recipient's~~ member's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the ~~service recipient~~ member. The direct support staffing is averaged across the week when the needs of the ~~service recipients~~ members in the household vary from day to day; and

(2) an average of eight hours of DLS has already been provided to the ~~service recipient~~ member each day that week.

(A) The provider cannot bill for additional support services unless 56 hours of DLS have been provided during the week to the ~~service recipient~~ member.

(B) If support services are provided to multiple ~~service recipients~~ members residing in the same household at the same time, the provider agency cannot count these hours toward each ~~service recipient's~~ member's 8-hour minimum. For example, three hours of service provided simultaneously by a single direct contact staff to three ~~residents~~ members in the same household may only be counted as three hours of service for one of the ~~service recipients~~ members, not three hours for each ~~resident~~ member.

(i) **Therapeutic leave.** Therapeutic leave is a ~~Medicaid~~ SoonerCare payment made to the Daily Living Supports contract provider to enable the ~~service recipient~~ member to retain personal care services.

(1) Therapeutic leave is claimed when the ~~service recipient~~ member does not receive Daily Living Supports services for 24 consecutive hours from 12:00 a.m. to 11:59 p.m. because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. Daily living supports staff ~~are~~ may be

present with the ~~service recipient~~ member in the hospital as approved by the ~~service recipient's~~ member's Team in the Individual Plan. Staff are present in the role of a visitor and are not responsible for the care of the patient.

(2) A ~~service recipient~~ member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) To promote continuity of direct support staff in the ~~service recipient's~~ member's absence, the provider pays the staff member the salary that he or she would have earned if the ~~service recipient~~ member were not on therapeutic leave if the provider is unable to provide an alternative work opportunity.

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 18 years of age or older. Upon approval of the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) director or designee, persons younger than 18 may be served.

(1) Group homes ensure members 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 DDSD in accordance with Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may be approved only by the DDSD director or designee to resolve a temporary emergency when no other resolution exists, or in a community living group home when the needs are so extensive that additional supports are needed for specific activities at identified times and the resulting plan of care is the most cost effective option. A weekly average of eight hours per day of direct contact staff must be provided per resident receiving community living group home services before HTS services may be claimed.

(b) **Minimum provider qualifications.** Approved providers must have a current ~~contract~~ provider agreement with the Oklahoma Health Care Authority (OHCA) to provide DDSD Home and Community-Based Services (HCBS) ~~Waiver~~ for persons with mental retardation or related conditions.

(1) Group home providers must have a completed and approved application to provide DDSD group home services.

(2) Group home staff must:

(A) complete the OKDHS DDSD-sanctioned training curriculum per OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening per OAC 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

(A) meet all applicable requirements of OAC 340:100; and

(B) are provided in accordance with each member's Individual Plan (IP) developed per OAC 340:100-5-50 through 340:100-5-58.

(i) Health care services are secured for each member per OAC 340:100-5-26.

(ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(2) Group home providers:

(A) follow protective intervention practices per OAC 340:100-5-57 and 340:100-5-58;

(B) in addition to the documentation required per OAC 340:100-3-40, must maintain:

(i) staff time sheets that document the hours each staff was present and on duty in the group home; and

(ii) documentation of each member's presence or absence on ~~the~~ a daily attendance form ~~provided by DDSD~~; and

(C) 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.

(d) **Coverage limitations.** 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 HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than 12 members per OAC 340:100-6.

(2) **Community living homes.** Community living homes serve no more than 12 members.

(A) Members who receive community living home services ~~have~~:

(i) have needs that cannot be met in a less structured setting; and

~~(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 member's health and safety; or~~

(ii) require regular, frequent, and sometimes constant assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

~~(iii) complex needs requiring frequent:~~

~~(I) assistance in the performance of activities necessary for daily living, such as frequent~~

~~assistance of staff for positioning, bathing, or other necessary movement;~~ or

(~~II~~iii) require supervision and training in appropriate social and interactive skills, due to on-going behavioral issues ~~in order~~ to remain included in the community.

(B) Services offered in a community living home include:

(i) 24-hour awake supervision when a member'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.

(C) Services may be approved for individuals in a traditional group home at the community living service rate if the member has had a change in health status or behavior and meets requirements to receive community living home services. Requests to receive community living home services are sent to the DDSD Community Services Residential Unit.

(3) **Alternative group homes.** Alternative group homes serve no more than four members 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) Members who receive alternative group home services must meet criteria per in OAC 340:100-5-22.6.

(B) A determination must be made by the DDSD Community Services Unit that alternative group home services are appropriate.

317:40-5-153. Daily Living Supports for the Homeward Bound Waiver

(a) **Introduction.** Daily Living Supports are provided by an agency with a valid ~~OHCA~~ Oklahoma Health Care Authority (OHCA) contract~~, approved by DDSD, for the service~~.

(1) Daily Living Supports require meeting the daily support needs of the ~~people~~ member living in the home.

(A) In accordance with the needs of the class member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the ~~person~~ member performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports are provided by staff that do not live in the home ~~also~~ and include assistance with cognitive tasks or provision of services to prevent ~~an individual~~ a member from harming self or others, in accordance with the needs of the ~~person receiving services~~ member.

(C) Daily Living Supports also include:

(i) the provision of staff training per OAC 340:100-3-30 to meet the specific needs of the ~~service recipient~~ member;

(ii) program supervision that includes 24-hour availability of response staff to meet schedules and unpredictable needs; ~~and~~

(iii) program oversight~~.~~;

(iv) assisting the member in obtaining services and supplies;

(v) developing and assuring emergency plans are in place;

(vi) coordinating overall safety and supports in the home; and

(vii) assisting members with personal money management.

(2) Daily Living Supports are used to provide and fund up to eight hours per day of supports for class members receiving supported living services ~~as detailed in~~ per OAC 340:100-5-22.5.

(b) **Eligibility.** Daily Living Supports, as described in this Section, are provided to ~~individuals~~ members who:

(1) are members of the class certified in Case Number 85-C-437-E, U.S. District Court for the Northern District of Oklahoma;

(2) receive community residential services in their own home; and

(3) do not simultaneously receive any other community residential or group home services.

(c) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

(1) ensure ongoing supports as needed to all ~~service recipients~~ members living in the home when one or more ~~service recipients~~ members is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) ensure compliance with all applicable DDSD policy found at OAC 340:100; ~~and~~

(3) provide for the welfare of all ~~service recipients~~ members living in the home~~.~~ ; and

(4) ensure that trained staff are available as described in the member's individual plan.

(d) **Criteria for direct support staff services in the Homeward Bound Waiver beyond eight hours per day.** Additional direct support services including HTS, Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section, are provided based on needs identified by the Personal Support Team and are considered in accordance with subsection (f) of this Section.

(e) **Daily Living Supports claims.** No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each ~~individual receiving services~~ member.

(1) The provider agency claims one unit of service for each day the ~~individual~~ member receives Daily Living Supports.

(2) Providers must claim at least monthly for all days that Daily Living Supports were actually provided during the preceding month. Claims must not be based on budgeted amounts.

(3) When ~~an individual~~ a member changes provider agencies, only the outgoing service provider agency claims for the day that the ~~individual~~ member moves.

(f) **Billing for other support services.** ~~The provider agency may claim separately for additional support services such as HTS, Intensive Personal Supports, or Homemaker Services provided to an individual~~ Additional support services such as HTS, Intensive Personal Supports, or Homemaker Service may be provided to a member receiving Daily Living Supports, if:

(1) additional support services have been authorized in the ~~person's~~ member's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the member. The direct support staffing is averaged across the week when the needs of the members in the household vary from day to day; and

(2) an average of eight hours ~~of direct staff support, excluding Nursing, have already been provided to the person that day.~~ of DLS has already been provided to the member each day that week. ~~If support services are provided to multiple individuals residing in the same household at the same time, the provider agency cannot count these hours toward each individual's eight-hour minimum. For example, three hours of HTS provided simultaneously by a single direct contact staff to three residents in the same household may only be counted as three hours of HTS for one of the individuals, not three hours for each resident.~~

(g) **Therapeutic leave.** Therapeutic leave is a Medicaid payment made to the Daily Living Supports contract provider to enable the ~~service recipient~~ member to retain direct support services.

(1) Therapeutic leave is claimed when the ~~service recipient~~ member does not receive Daily Living Supports services for 24 consecutive hours because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. Daily living supports staff ~~are~~ may be present with the ~~individual~~ member in the hospital as approved by the ~~person's~~ member's Team in the Individual Plan. Staff are present in the role of a visitor and are not responsible for the care of the patient.

(2) ~~An individual~~ A member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) If, because of the ~~service recipient's~~ member's absence, the direct support staff ~~member~~ is unable to work, the provider pays the staff ~~member~~ the salary that he or she would have earned if the ~~service recipient~~ member were not on therapeutic leave.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-12. Enhanced rates

An Enhanced Rate is available for both Community-Based Group Services and Group Job Coaching Services~~.~~ when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per OAC 340:100-5-56 and assessment of medical, nutritional, and mobility needs and:

(1) ~~Eligibility for an enhanced rate is determined by~~ Team assessment ~~as detailed in~~ per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and ~~subsection (d) of~~ OAC 340:100-5-26 of the ~~service recipient's~~ member's needs.

(2) ~~To be eligible for the enhanced rate,~~ the ~~service recipient~~ member must:

(A) have a protective intervention plan that:

(i) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(ii) has been approved by the State Behavior Review Committee (SBRC) in accordance with OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff ~~in accordance with subsection (g) of~~ per OAC 340:100-5-57; and

(iii) has been reviewed by the Human Rights Committee (HRC) ~~in accordance with~~ per OAC 340:100-3-6;

(B) have procedures included in the Individual Plan which address dangerous behavior that places the ~~service recipient~~ member or others at risk of serious physical harm but are neither restrictive or intrusive procedures as defined in OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to assure that positive approaches are being used to manage dangerous behavior;

(C) have a visual impairment that requires assistance for mobility or safety;

(D) have two or more of the circumstances given in this subparagraph.

(i) The ~~service recipient~~ member has medical support needs which are rated at Level 4, Level 5, or Level 6 on the Physical Status Review (PSR), explained in OAC 340:100-5-26 or a comparable level of high medical needs as documented in the Plan.

(ii) The ~~service recipient~~ member has nutritional needs ~~supported by the PSR~~ requiring tube feeding or other dependency for food intake which must occur in the employment setting.

(iii) The ~~service recipient~~ member has mobility needs, ~~supported by the PSR,~~ such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology has been evaluated for the current employment program and determined

not feasible by the DDSD division director or designee; or

(E) reside in alternative group home as described in OAC 317:40-5-152.

(3) The enhanced rate can be claimed only if the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38.

(4) There are no exceptions for the enhanced rate other than as allowed in this Section.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in OAC 317:40-7 are:

(1) approved in accordance with OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the Personal Support Team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan ~~(IP)~~ (Plan) process per OAC 340:100-5-50 through 340:100-5-58; and

(4) documented and recorded on Oklahoma Department of Human Services (OKDHS) Form 06WP047E, Exception Request for Waiver Employment Services, by the Developmental Disabilities Services Division (DDSD) case manager after Team approval.

(b) A request for an exception to the minimum of 30 hours per week of employment services, adult day services per OAC 317:40-5-113, or a combination of both, per OAC 317:40-7-15, includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans;

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and

(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.

(c) A request for an exception to the maximum limit of 15 hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(d) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(e) Within ten working days of the annual ~~IP~~ Individual Planning or interim meeting, the DDSD case manager sends OKDHS Form 06WP047E to area employment services staff, who reviews the form to ensure all criteria per OAC 317:40-7-21 are met. If criteria are:

(1) not met, employment services staff returns OKDHS Form 06WP047E with recommendations to the DDSD case management supervisor and case manager for resubmission; or

(2) met, employment services staff returns OKDHS Form 06WP047E to the case management supervisor to resume the approval process and input of units on the member's Plan of Care.

(f) Exception requests per OAC 340:40-7-21(f) are documented by the DDSD case manager after Team consensus and submitted via OKDHS Form 06WP047E to the DDSD area manager within ten working days after the annual IP or interim Team meeting. The area manager approves or denies the request with a copy to the DDSD area office claims staff and case manager based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives.

(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:

(A) Team's discussion of current specific situation that requires an exception;

(B) specific medical issues necessitating the exception request; and

(C) a projection of units needed to complete the State fiscal year.

(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans.

(g) The DDSD director or designee may review exceptions granted ~~in accordance with~~ per OAC 317:40-7-21, directing the Team to provide additional information, if necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.

[OAR Docket #10-796; filed 5-7-10]

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

[OAR Docket #10-784]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 11. Insure Oklahoma/O-EPIC IP
Part 5. Insure Oklahoma/O-EPIC IP Member Eligibility
317:45-11-20. [AMENDED]
317:45-11-27. [AMENDED]
(Reference APA WF # 09-53)
AUTHORITY:
The 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 11. Insure Oklahoma/O-EPIC IP
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317:45-11-27. [AMENDED]
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N/A
ANALYSIS:
Insure Oklahoma/O-EPIC rules are revised to clarify the intent of offering coverage under the Individual Plan (IP) program. Applicants applying for coverage under the IP program should be uninsured individuals without access to Employer Sponsored Insurance (ESI) or other private health insurance. It has never been the intent of Insure Oklahoma IP to be a secondary payer for services rendered under ESI or any other private health insurance policy or plan. Rules clarify IP eligibility requirements and closure criteria.
CONTACT PERSON:
Tywanda Cox at 522-7153

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 11, 2010:

SUBCHAPTER 11. INSURE OKLAHOMA/O-EPIC IP

PART 5. INSURE OKLAHOMA/O-EPIC IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma/O-EPIC IP eligibility requirements

(a) Employees not eligible to participate in an employer's QHP, employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI.

(b) The eligibility determination is processed within 30 days from the date the complete application is received by the TPA. The applicant is notified in writing of the eligibility decision.

(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;

(2) be a US citizen or alien as described in OAC 317:35-5-25;

(3) be an Oklahoma resident;

(4) provide social security numbers for all household members;

(5) be not currently enrolled in, or have an open application for, SoonerCare/Medicare;

(6) be age 19 through 64 or an emancipated minor;

(7) make premium payments by the due date on the invoice; ~~and~~

(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2)~~.~~; and

(9) be not currently covered by a private health insurance policy or plan.

(d) If employed and working for an approved Insure Oklahoma/O-EPIC employer who offers a QHP, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have household income at or below 200% of the Federal Poverty Level.

(2) be ineligible for participation in their employer's QHP due to number of hours worked.

(3) have received notification from Insure Oklahoma/O-EPIC indicating their employer has applied for Insure Oklahoma/O-EPIC and has been approved.

(e) If employed and working for an employer who doesn't offer a QHP, the applicant must meet the requirements in subsection (c) of this Section and have a countable household income at or below 200% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) must have household income at or below 200% of the Federal Poverty Level;

(2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms;

(3) verify current income by providing appropriate supporting documentation; and

(4) must not be employed by any full-time employer who meets the eligibility requirements in OAC 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicant must have household income at or below 200% of the Federal Poverty Level~~; and~~. In determining income, payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, will not be counted, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

(2) Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) OESC eligibility letter,

(B) OESC weekly unemployment payment statement, or

(C) bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and:

(1) must have household income at or below 200% of the Federal Poverty Level based on a family size of one; and

(2) verify eligibility by providing a copy of their:

(A) ticket to work, or

(B) ticket to work offer letter.

317:45-11-27. Closure

(a) Members are mailed a notice 10 days prior to closure of eligibility.

(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma/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 Insure Oklahoma/O-EPIC;

(7) the member fails to pay the amount due within 60 days of the date on the bill;

(8) the QHP or carrier is no longer qualified;

(9) the member begins receiving SoonerCare/Medicare benefits; ~~or~~

(10) the member begins receiving coverage by a private health insurance policy or plan; or

(~~10~~ 11) 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) through (c) and 317:45-11-20(f) through (h). The member'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 member fails to pay the amount due within 60 days of the date on the bill;

(7) the member becomes eligible for SoonerCare/Medicare; ~~or~~

(8) the member begins receiving coverage by a private health insurance policy or plan; or

(~~8~~ 9) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

[OAR Docket #10-784; filed 5-7-10]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #10-753]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 1. General Provisions
365:1-1-4.1. Fees [AMENDED]
Subchapter 7. Hearings
365:1-7-9. Hearing procedure -emergency actions [AMENDED]
Subchapter 9. Description of Forms and Instructions
365:1-9-5. Surplus lines forms [AMENDED]
AUTHORITY:
Insurance Commissioner, 36 O.S. §§ 307.1, 348.1, 1107, and 75 O.S. § 314.1.
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SUPERSEDED EMERGENCY ACTIONS:
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INCORPORATIONS BY REFERENCE:
n/a
ANALYSIS:
The amendment to Section 365:1-1-4.1 changes the authority for the Insurance Commissioner to collect fees and licenses from the State Board of Property and Casualty Rates to the Rate and Form Compliance Division of the Insurance Department.

The amendment to Section 365:1-7-9 clarifies the number of days for requesting a hearing in emergency actions. The amendment specifies that within ten business days, the Insurance Department must conduct a hearing in emergency actions if the affected individual requests such a hearing.

The amendment to Section 365:1-9-5 removes the requirement that surplus lines brokers file affidavits in duplicate and requires surplus lines to file an affidavit in one-part instead.
CONTACT PERSON:
Melanie Pouncey Sullivan, Assistant General Counsel, Oklahoma Insurance Department, 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112, (405) 521-2749

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 14, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

365:1-1-4.1. Fees

The Oklahoma Insurance Department is required and provided for by the following laws to collect certain fees as follows:

(1) **36 O.S. §311.1.** Provides a late fee required with annual statements filed after the first day of March.

(2) **36 O.S. §321.** Provides for the following fees:

(A) Copies 40¢ per page.

(B) Appointing Commissioner as agent for service of process.

(C) Licensure and reporting requirements for company licensing, mergers and acquisitions.

(D) Life, Accident and Health policy filings.

(E) Amendments to by-laws and articles.

(F) Retaliatory fees.

(3) **36 O.S. §348.1.** Authorizes the Commissioner to collect fees and licenses for the ~~State Board for Property and Casualty Rates~~ Rate and Form Compliance Division of the Insurance Department.

(4) **36 O.S. §621.** Summons process fees.

(5) **36 O.S. §628.** Life, Accident and Health policy filings retaliatory fee.

(6) **36 O.S. §635.** Initial application fee and annual renewal for Multiple Employer Welfare Arrangements (MEWAs).

(7) **36 O.S. §1115.** Surplus lines taxes.

(8) **36 O.S. § 1435.23(A)(4)(c).** Crop hail licensure fees.

(9) **36 O.S. § 1435.23 and § 1435.29.** Fees and licenses for insurance agents, surplus lines insurance brokers, and limited insurance representatives. Also includes annual fee for agents continuing education providers.

(10) **36 O.S. §1450.** TPA license fee.

(11) **36 O.S. §1464.** Broker license fee

(12) **36 O.S. §1661.** Holding company registration fee.

(13) **36 O.S. §2126.1.** Solicitation and trade fee.

(14) **36 O.S. §2731.** Fraternal license and appointment.

(15) **36 O.S. §3105.** Motor club license and appointment.

(16) **36 O.S. §6124.** Provides for initial fee and renewal fee for prepaid funeral benefits organizations.

(17) **36 O.S. §6130, §1659.** Fines and $5 service charges.

(18) **36 O.S. §6144.** Prepaid Dental Company License

(19) **36 O.S. §6212.** Adjuster's exams, license and manuals fees.

(20) **36 O.S. §6465.** Risk retention group filing fees and purchasing group filing fees.

(21) **36 O.S. §6557, §6559, §6560 and 74 O.S. §1306.2(B).** Provides for application and renewal fees for entities performing utilization review.

(22) **36 O.S. §6604.** Provides for a license fee for service warranties licensure.

(23) **51 O.S. §24A.1 et seq.** - The Open Records Act provides authority to charge reasonable fees to provide information requested by the public. The Act authorizes a "search fee" when records are requested for commercial purposes. The Data Processing Division of the Insurance

Department makes certain computer records available upon request. A schedule of the records available and the current fee for each is available upon request from this Division.

(24) **59 O.S. §1305, §1308, §1308.1, §1309, §1314(d) and §1317(a).** Provide for license fees, investigation fees, annual fees for OBA, examination fees, renewal fees and appointment fees for bail bondsmen.

(25) **59 O.S. §858-708.** Gives the Insurance Department authority to collect fees for licensure and examination fees for Real Estate Appraisers.

(26) **68 O.S. §50001.** Fire Marshall tax.

SUBCHAPTER 7. HEARINGS

365:1-7-9. Hearing procedure-emergency actions

(a) If the public health, safety, or welfare imperatively requires emergency action, such action, including the suspension of a license instanter, may be ordered pending the final outcome of proceedings instituted by the Insurance Department. In such cases, the Insurance Department shall notify the affected individual or entity of such action by certified mail, return receipt requested, and shall include in such notice a provision that the individual or entity may request a hearing concerning the emergency action. A request for a hearing concerning the emergency action shall be made in writing to the legal division of the Insurance Department. Upon such written request for hearing, the Insurance Department shall conduct the hearing within ten business days ~~of~~ after receipt of the request~~, and the~~ . The hearing shall be conducted by an independent hearing examiner. If an independent hearing examiner is not available within ten business days, the hearing shall be set within a reasonable time.

(b) The individual or entity affected may make arrangements for a court reporter to be present at and record the hearing concerning the emergency action. All costs associated with the court reporter shall be borne by said individual or entity.

(c) An individual or entity who requests a hearing pursuant to this regulation may appeal the ruling of the hearing examiner by filing a petition in Oklahoma County District Court, within thirty (30) days after the individual or entity is notified of the order of the hearing examiner. Copies of the petition shall be served upon the Insurance Department and all other parties of record, and proof of such service shall be filed in the district court within ten (10) days after the filing of the petition.

SUBCHAPTER 9. DESCRIPTION OF FORMS AND INSTRUCTIONS

365:1-9-5. Surplus lines forms

(a) **Surplus lines broker quarterly summary form.** The surplus lines broker quarterly summary includes forms that detail the types of coverages written, the aggregate amount of insurance issued, the gross premiums charged, and the gross return premium. Form SL-3a must be signed by the broker with an original/live signature, notarized, and filed on or before the last day of the month following the close of a calendar quarter. The specific forms are:

(1) SL-3a Affidavit of a true and correct report. File in ~~duplicate~~ one-part.

(2) SL-3b Spreadsheet to accumulate premium and tax data by the company number and company name of the surplus line carrier. File in one-part only.

(3) SL-3c Affidavit of coverage. File in one-part.

(4) SL-3d Affidavit for return of premiums and the credit or refund of premium taxes.

(b) **Surplus lines direct placement by an insured summary form.** The direct placement by an insured summary includes forms that detail the types of coverages written, the aggregate amount of insurance issued, the gross premiums charged, the gross return premium, and the tax due. Form DSL-3a must be signed by the affiant, generally the individual responsible for procuring risk coverage, with an original signature, notarized and filed within thirty (30) days next succeeding the issuance of evidence of coverage. The specific forms are:

(1) DSL-3a Affidavit of a true and correct report. File in ~~duplicate~~ one-part.

(2) DSL-3b Spreadsheet to accumulate premium and tax data by the company number and company name of the surplus lines carrier. File in one part only.

(3) DSL-3c Affidavit of coverage. File in one-part.

(4) DSL-3d Affidavit for return of premiums and the credit or refund of premium taxes.

[OAR Docket #10-753; filed 5-4-10]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 10. LIFE, ACCIDENT AND HEALTH

[OAR Docket #10-754]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 1. General Provisions
Part 1. General Provisions
365:10-1-14. Notice of withdrawal or discontinuance of writing [NEW]
Subchapter 5. Minimum Standards; Contract Guidelines
Part 1. Minimum Standards and Benefits for Accident and Health Insurance
365:10-5-9. Disclosure of reasonable charge determination [NEW]
Part 5. Long-Term Care Insurance
365:10-5-45.1 Reporting requirements [AMENDED]
365:10-5-55. Availability of new services or providers [AMENDED]
Part 17. Actuarial Opinion and Memorandum Regulation
365:10-5-177. Description of actuarial memorandum including an asset adequacy analysis [AMENDED]
Subchapter 15. Utilization Review Regulations
365:10-15-2. Private review agents [AMENDED]
Subchapter 17. Valuation of Life Insurance Policies Regulation (Including the Introduction and Use of New Select Mortality Factors)
365:10-17-4. General calculation requirements for basic reserves and premium deficiency reserves [AMENDED]
Subchapter 25. Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities
365:10-25-4. 2001 CSO preferred class structure table [AMENDED]
365:10-25-5. Conditions [AMENDED]

Appendix CC. Long-Term Care Insurance Claims Denial Reporting Form [REVOKED]
Appendix CC. Long-Term Care Insurance Claims Denial Reporting Form [NEW]

AUTHORITY:
Insurance Commissioner, 36 O.S. §§ 307.1, 311, 1466, 4427, 4502(B)(9)(d)(2), 6516(A)(6), 6555, and 6571.

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Subchapter 5. Minimum Standards; Contract Guidelines
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365:10-5-177. Description of actuarial memorandum including an asset adequacy analysis [AMENDED]
Subchapter 17. Valuation of Life Insurance Policies Regulation (Including the Introduction and Use of New Select Mortality Factors)
365:10-17-4. General calculation requirements for basic reserves and premium deficiency reserves [AMENDED]
Subchapter 25. Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities
365:10-25-4. 2001 CSO Preferred Class Structure Table [AMENDED]
365:10-25-5. Conditions [AMENDED]
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27 Ok Reg 315
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09-1378

INCORPORATIONS BY REFERENCE:
n/a

ANALYSIS:
The new Section 365:10-1-14 provides notice requirements for an insurer who desires to withdraw from writing insurance in Oklahoma.

The new Section 365:10-5-9 provides disclosure requirements for contracts or certificates of insurance which base payment for health care services, procedures or supplies on a determination of average area charges for those services, procedures or supplies. The new section also defines average area charge and provides requirements for the disclosure.

The amendment to Section 365:10-5-45.1 adds the definitions of claim, denied and report to the existing language as a result of the adoption of these amendments by the National Association of Insurance Commissioners.

The amendment to Section 365:10-5-55 changes the effective date of the section to July 14, 2009 in order to update the reference to the effective date.

The amendment to Section 365:10-5-177 clarifies a requirement of the regulatory asset adequacy issues summary.

The amendment to Section 365:10-15-2 updates the statutory reference for health maintenance organizations to reflect the relevant health maintenance organization sections of law within Title 36 of the Oklahoma Statutes.

The amendment to Section 365:10-17-4 deletes requirements for which certain select mortality factors are subject; specifically that the percentage not be less than twenty percent (20%) and that the percentage not decrease in any successive policy years. The amendment also adds the requirement of disclosure by the actuary if the percentage is less than one hundred percent (100%) at any duration for any policy. The actuary shall disclose the impact of the insufficiency of assets to support payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods.

The amendment to Section 365:10-25-4 allows for the substitution of the 2001 CSO Preferred Class Structure Mortality Table and 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies with the consent of the Commissioner subject to the conditions set forth in 365:10-25-5. Section 365:10-25-5 is amended to prohibit the use of the 2001 CSO Preferred Class Structure Table for the valuation of policies issued prior to January 1, 2007 if particular frequencies of modes of payment of the reinsurance premium exist.

The revocation and reenactment of Appendix CC adds the manner of reporting long-term care denials to the instruction sections section of the appendix. The appendix specifies what is not included in the definition of a denied claim and adds a field to the form regarding the total number of In-force Policies as of the end of the year. The revocation and reenactment are the result of adoptions by the National Association of Insurance Commissioners.

CONTACT PERSON:
Melanie Pouncey Sullivan, Assistant General Counsel, Oklahoma Insurance Department, 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112, (405) 521-2749

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 14, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

PART 1. GENERAL PROVISIONS

365:10-1-14. Notice of withdrawal or discontinuance of writing

(a) Any insurer desiring to withdraw from the state or discontinue the writing of a particular type or class of insurance in this state shall give one hundred eighty (180) days notice in writing to the Rate and Form Filing Compliance Division of the Insurance Department and shall state in writing its reasons for such action. The insurer shall also provide the following information:

(1) The number of policyholders affected;
(2) The number of insurance agents affected;
(3) The date the insurer will cease writing new business;
(4) The date the insurer will start non-renewing insurance policies;
(5) Whether the insurer has made arrangements with another insurer to cover the renewals;
(6) The lines of insurance on which the insurer plans to concentrate; and
(7) Whether the insurer anticipates re-entering the market.

(b) The provision of information required by subsection (a) of this section by an insurer electing to nonrenew all of its health benefit plans issued in this state that are subject to the Health Insurance Portability and Accountability Act, Public Law 104-194, shall constitute compliance with the obligations of the insurer to report to the Insurance Commissioner pursuant to 36 O.S. § 4502(B)(9)(d)(2).

(c) The provision of information required in this section by a small employer carrier electing to nonrenew all of its health benefit plans issued to small employers in this state shall constitute compliance with the obligations of the small employer carrier to report to the Insurance Commissioner pursuant to 36 O.S. § 6516(A)(6).

SUBCHAPTER 5. *MINIMUM STANDARDS; CONTRACT GUIDELINES*

PART 1. *MINIMUM STANDARDS AND BENEFITS FOR ACCIDENT AND HEALTH INSURANCE*

365:10-5-9. Disclosure of reasonable charge determination

(a) Any contract or certificate of insurance issued by an insurance company, not-for-profit hospital service and medical indemnity plan, health insurance service organization or preferred provider organization which bases its payment for health care services, procedures, or supplies on a determination of average area charges for health care services, procedures, or supplies shall disclose that information to the contract purchaser and certificate holder at the time that the policy or certificate is delivered.

(b) Average area charge means any determination of a charge for health care services, procedures, or supplies on a basis other than the billed rate or contracted rate of the health care provider. For example, average area charge includes, but is not limited to, the terms customary and reasonable, usually and customary, usual, customary, and reasonable, or other similar terms.

(c) The disclosure shall be located on the first page or in a separate document affixed to the front page of the contract or certificate. The disclosure shall:

(1) Be appropriately captioned and printed in font size at least two (2) points larger than the other text of the policy.

(2) Reference the applicable section of the contract or certificate that specifies how average area charges are determined and provide an example of how this determination will affect the payment for services, procedures, or supplies of a health care provider. This example shall provide an explanation of the liability for charges of the insured that exceed the average area charge.

(3) Advise the insured of the provisions of 36 O.S. § 6571 and provide a point of contact for health care providers to request the information used to determine the average area charge.

(4) Include language advising the insured that noncompliance with 36 O.S. § 6571 should be reported to the Oklahoma Insurance Department.

PART 5. LONG-TERM CARE INSURANCE

365:10-5-45.1. Reporting requirements

(a) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(b) Each insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by (a) of this section.

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(f) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. An insurer shall use the form in Appendix CC to comply with this provision.

(g) For purposes of this section~~, policy shall mean~~:

(1) Policy means only long-term care insurance~~ and report~~;

(2) Subject to paragraph 3 of this subsection, claim means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(3) Denied means the insurer refused to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(4) Report means on a statewide basis.

(h) Reports required under this section shall be filed with the commissioner.

365:10-5-55. Availability of New Services or Providers

(a) An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date of the new policy series is made available for sale in this state.

(b) Notwithstanding Subsection (a) of this section, notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require

that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(c) The insurer shall make the new coverage available in one of the following ways:

(1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) By an alternative program developed by the insurer that meets the intent of this Section if the program is filed with and approved by the commissioner.

(d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this Subsection, limited distribution channel means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(e) Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to O.A.C. 365:10-5-45 and 365:10-5-48.5, and the reporting requirements of O.A.C. 365:10-5-45.1(a)-(e).

(f) Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection (a) of this section shall be made to the offering entity. However, if the policy is issued to a group defined at Section 4424(4)(a) of Title 36, the notification shall be made to each certificateholder.

(g) Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(h) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(i) This section shall become effective on or after July 14, ~~2008~~ 2009.

PART 17. ACTUARIAL OPINION AND MEMORANDUM REGULATION

365:10-5-177. Description of actuarial memorandum including an asset adequacy analysis

(a) **General.**

(1) In accordance with Section 4061 of the Oklahoma Insurance Code, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the Commissioner upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the Insurance Department or subject to automatic filing with the Commissioner.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Rule 365:10-5-173(b) of this regulation, with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the Commissioner requests a memorandum and no such memorandum exists or if the Commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the Commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the Commissioner.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the Commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the Commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the Commissioner pursuant to the statute governing this regulation. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for any one of the current year or the preceding three (3) years.

(5) In accordance with Section 4061 of the Oklahoma Insurance Code, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection (c). The regulatory

asset adequacy issues summary will be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(b) **Details of the memorandum documenting asset adequacy analysis.** When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Rule 365:10-5-173(d) of this regulation and any additional standards under this regulation. It shall specify:

(1) For reserves:

(A) Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

(B) Source of liability in force;

(C) Reserve method and basis;

(D) Investment reserves;

(E) Reinsurance arrangements

(F) Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;

(G) Documentation of assumptions to test reserves for the following (The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.):

(i) Lapse rates (both base and excess);

(ii) Interest crediting rate strategy;

(iii) Mortality;

(iv) Policyholder dividend strategy;

(v) Competitor or market interest rate;

(vi) Annuitization rates;

(vii) Commissions and expenses; and

(viii) Morbidity.

(2) For assets:

(A) Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

(B) Investment and disinvestment assumptions;

(C) Source of asset data;

(D) Asset valuation bases;

(E) Documentation of assumptions made for (The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.):

(i) Default costs;

(ii) Bond call function;

(iii) Mortgage prepayment function;

(iv) Determining market value for assets sold due to disinvestment strategy; and

(v) Determining yield on assets acquired through the investment strategy.

(3) Analysis basis:

(A) Methodology;

(B) Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

(C) Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of materiality that was used in determining how rigorously to analyze different blocks of business);

(D) Criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under moderately adverse conditions or other conditions as specified in relevant actuarial standards of practice); and

(E) Effect of federal income taxes, reinsurance and other relevant factors.

(4) Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

(5) Summary of results; and

(6) Conclusions.

(c) **Details of the regulatory asset adequacy issues summary.**

(1) The regulatory asset adequacy issues summary shall include:

(A) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(B) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;

(C) The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

(D) Comments on any interim results that may be of significant concern to the appointed actuary. For example, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods;

(E) The methods used by the actuary to recognize the impact of reinsurance on the company's cash

flows, including both assets and liabilities, under each of the scenarios tested; and

(F) Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

(2) The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

(d) **Conformity to standards of practice.** The memorandum shall include the statement: Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum.

(e) **Use of assets supporting the interest maintenance reserve and the asset valuation reserve.**

(1) An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

(2) The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

(f) **Documentation.** The appointed actuary shall retain on file, for at least seven (7) years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

SUBCHAPTER 15. UTILIZATION REVIEW REGULATIONS

365:10-15-2. Private review agents

(a) The following persons or entities shall be considered private review agent(s) for purposes of the Hospital and Medical Services Utilization Review Act, ~~Okla. Stat. tit. 36, § 6551, et seq.~~ Sections 6551 through 6581 of Title 36 of the Oklahoma Statutes:

(1) Any person or entity who performs utilization review on behalf of an employer in this state. The term employer means any person or entity who employs any person in this state. No person or entity who performs utilization review on behalf of an employer in this state shall be exempt from the provisions of the Hospital and Medical Services Utilization Review Act on the basis that the employer is self-insured or participates in an ERISA exempt employee welfare benefit plan or multiple employer welfare arrangement;

(2) Any person or entity who performs utilization review on behalf of a health maintenance organization which has been issued a license pursuant to ~~Okla. Stat. tit. 63, § 2501 et seq.~~ Sections 6901 through 6936 of Title 36 of the Oklahoma Statutes. However, any such person or entity performing utilization review on behalf of a health maintenance organization so licensed shall be exempt from the provisions of the Hospital and Medical Services Utilization Review Act if, prior to performing utilization review, such person or entity has obtained written documentation from the health maintenance organization that:

(A) the health maintenance organization is federally regulated; and

(B) the health maintenance organization has filed with the Commissioner of Health a plan of utilization review which is carried out by health care professionals and which has established complaint and appellate procedures for claims;

(3) Any person or entity who performs utilization review on behalf a third party providing or administering hospital and medical benefits to citizens of this state, including but not limited to a health insurer, not-for-profit hospital service or medical plan, health insurance service organization, preferred provider organization or other entity offering health insurance policies, contracts or benefits in this state;

(b) Any licensed physician or other licensed health care professional who, pursuant to contract, agreement, or through the receipt or promise of any valid consideration, is consulted during the course of utilization review by a person or entity who is licensed to perform utilization review shall not be considered a private review agent.

(c) A private review agent whose provides utilization review services exclusively pursuant to a contract with the federal or state government concerning patients eligible for hospital and medical services under the Social Security Act is exempt from the certification required for private review agents in the Hospital and Medical Services Utilization Review Act.

(d) A private review agent who conducts in-house utilization review services solely for hospitals, home health agencies, preferred provider organizations, or other managed care entities, clinics, private offices or any other health facility or entity must be certified if the private review agent's review results in the approval or denial of payment for hospital and medical services on a particular case. If such private review agent's in-house utilization review is only of a general nature and does not result in the approval or denial of payment for such services on a case by case basis, no certification is required.

(e) A private review agent who conducts outside utilization review services for an insurance company, not-for-profit hospital service or indemnity plan, or a not-for-profit medical or indemnity plan, shall be certified in compliance with the Hospital and Medical Services Utilization Review Act.

(f) Individual employees of a certified private review agent need not be separately certified.

SUBCHAPTER 17. VALUATION OF LIFE INSURANCE POLICIES REGULATION (INCLUDING THE INTRODUCTION AND USE OF NEW SELECT MORTALITY FACTORS)

365:10-17-4. General calculation requirements for basic reserves and premium deficiency reserves

(a) At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the Insurance Commissioner for this purpose). If select mortality factors are elected, they may be:

(1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(2) The select mortality factors in the Appendix BB of this chapter; or

(3) Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the Insurance Commissioner for the purpose of calculating basic reserves.

(b) Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the Insurance Commissioner). If select mortality factors are elected, they may be:

(1) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

(2) The select mortality factors in the Appendix BB of this chapter of this regulation;

(3) For durations in the first segment, X percent of the select mortality factors in the Appendix BB of this chapter, subject to the following:

(A) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(B) ~~X shall not be less than twenty percent (20%);~~

~~(C) X shall not decrease in any successive policy years;~~

~~(D)~~ X is such that, when using the valuation interest rate used for basic reserves, unit (i) is greater than or equal to unit (ii);

(i) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

(ii) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

(~~E~~ C) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date;

(~~F~~ D) The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of Section 365:10-17-3(b)(3);

(~~G~~ E) The appointed actuary may decrease X at any valuation date as long as X ~~does not decrease in any successive policy years and as long as it~~ continues to meet all the requirements of Section 365:10-17-3(b)(3); and

(~~H~~ F) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(~~I~~ G) If X is less than 100 percent at any duration for any policy, the following requirements shall be met:

(i) The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of Section 365:10-5-176; and

(ii) The appointed actuary shall disclose, in the Regulatory Asset Adequacy Issues Summary, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods; and

(iii) The appointed actuary shall annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of X meet the requirements of Subsection B(3). This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

(4) Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the Insurance Commissioner for the purpose of calculating deficiency reserves.

(c) This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten (10) years, the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

(d) In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

(e) Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following: (1) reserves calculated ignoring the guarantee, (2) reserves assuming the guarantee was made at issue, and (3) reserves assuming that the policy was issued on the date of the guarantee.

(f) The Insurance Commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to the effective date of this regulation. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of Section 365:10-5-176.

SUBCHAPTER 25. REGULATION PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

365:10-25-4. 2001 CSO Preferred Class Structure Table

At the election of the company, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in this regulation, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. For policies issued on or after July 14, 2003, and prior to January 1, 2007, these tables may be substituted with the consent of the Commissioner and subject to the conditions of Rule 365:10-25-5. In determining such consent, the Commissioner may rely on the consent of the Commissioner of the company's state of domicile. No such election shall be made until the company demonstrates at least 20% of the business to be valued on this table is in one or more of the preferred classes. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, pursuant to the requirements of this rule, will be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation pursuant to the requirements of the NAIC model regulation, Recognition of the 2001 CSO Mortality Table For Use In Determining Minimum Reserve Liabilities And Nonforfeiture Benefits Model Regulation.

365:10-25-5. Conditions

(a) For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the residual standard nonsmoker table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(b) For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary shall certify that:

(1) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

(2) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table.

(c) Unless exempted by the commissioner, every authorized insurer using the 2001 CSO Preferred Class Structure Table shall annually file with the commissioner, with the NAIC, or with a statistical agent designated by the NAIC and acceptable to the commissioner, statistical reports showing mortality and such other information as the commissioner may deem necessary or expedient for the administration of the provisions of this regulation. The form of the reports shall be established by the commissioner or the commissioner may require the

use of a form established by the NAIC or by a statistical agent designated by the NAIC and acceptable to the commissioner.

(d) The use of the 2001 CSO Preferred Class Structure Table for the valuation of policies issued prior to January 1, 2007 shall not be permitted in any statutory financial statement in which a company reports, with respect to any policy or portion of a policy coinsured, either of the following:

(1) In cases where the mode of payment of the reinsurance premium is less frequent than the mode of payment of the policy premium, a reserve credit that exceeds, by more than the amount specified in this paragraph as Y, the gross reserve calculated before reinsurance. Y is the amount of the gross reinsurance premium that

(A) provides coverage for the period from the next policy premium due date to the earlier of the end of the policy year and the next reinsurance premium due date, and

(B) would be refunded to the ceding entity upon the termination of the policy.

(2) In cases where the mode of payment of the reinsurance program is more frequent than the mode of payment of the policy premium, a reserve credit that is less than the gross reserve, calculated before reinsurance, by an amount that is less than the amount specified in this paragraph as Z. Z is the amount of the gross reinsurance premium that the ceding entity would need to pay the assuming company to provide reinsurance coverage from the period of the next reinsurance premium due date to the next policy premium due date minus any liability established for the proportionate amount not remitted to the reinsurer.

(e) For purposes of subsection (d) of this section, both the reserve credit and the gross reserve before reinsurance (i) for the mean reserve method shall be defined as the mean reserve minus the deferred premium asset, and (ii) for the mid-terminal reserve method shall include the unearned premium reserve. A company may estimate and adjust its accounting on an aggregate basis in order to meet the conditions to use the 2001 CSO Preferred Class Structure Table.

APPENDIX CC. LONG-TERM CARE INSURANCE CLAIMS DENIAL REPORTING FORM [REVOKED]

APPENDIX CC. LONG-TERM CARE INSURANCE CLAIMS DENIAL REPORTING FORM [NEW]

For the State of _____
For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____
_____
Company NAIC Number: _____
Contact Person: _____ Phone Number: _____
Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. Indicate the manner of reporting by checking one of the options below:

___ Per Claimant – counts each individual who makes one or a series of claim requests.

___ Per Transaction – counts each claim payment request.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. "Denied" does not include a request for payment that is in excess of the applicable contractual limits.

In-force Data

	State Data	Nationwide Data[1]
Total Number of In-force Policies [Certificates] as of December 31st		

Claims and Denial Data

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		

[1] The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	Long-Term Care Services Not Covered under the Policy[2]		
9	Provider/Facility Not Qualified under the Policy[3]		
10	Benefit Eligibility Criteria Not Met[4]		
11	Other		

[2] Example—home health care claim filed under a nursing home only policy.

[3] Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

[4] Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

[OAR Docket #10-754; filed 5-4-10]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 15. PROPERTY AND CASUALTY

[OAR Docket #10-755]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 1. General Provisions
365:15-1-3. Property and casualty form filings [AMENDED]
365:15-1-18. Withdrawal or discontinue writing [AMENDED]
365:15-1-22. Processing fee for affidavit of exempt status [REVOKED]
Subchapter 7. Property and Casualty Competitive Loss Cost Rating Regulations
365:15-7-3. Property and casualty rate, loss cost and manual rule filings [AMENDED]
365:15-7-16. Statistical plans [AMENDED]
365:15-7-31. Withdrawal or discontinue writing [AMENDED]
365:15-7-32. Use of "A" rates [AMENDED]
Subchapter 9. Medical Professional Liability Rate Setting
365:15-9-3. Notice to policyholders [AMENDED]
365:15-9-10. Property and casualty rate, loss cost and manual rule filings [AMENDED]
365:15-9-18. Statistical Plans [AMENDED]
365:15-9-22. Withdrawal or discontinue writing [NEW]
Appendix D. Format for Notification to Policyholders of Application for Rate Change [REVOKED]
Appendix D. Format for Notification to Policyholders of Application for Rate Change [NEW]
AUTHORITY:
Insurance Commissioner, 36 O.S. §§ 307.1, 924.4, 986, 987, and 6812.1
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February 25, 2010
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March 8, 2010
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n/a
ANALYSIS:

The amendment to Section 365:15-1-3 removes a paragraph exempting filing fees for certain transactions, such as error corrections and changes in company logos for approved filings since all filings are required to be submitted electronically. The amendment also requires electronic filings through the System for Electronic Rate and Form Filing (SERFF) pursuant to SERFF General Instructions. The amendment changes the requirement for filing two (2) copies with the Insurance Department to filing one (1) copy. Notices of action taken by the Insurance Commissioner shall also be through the SERFF. The amendment allows for adoption of certain Advisory Organization forms and materials by participating insurers of a licensed advisory organization. The amendment corrects a typographical error. The amendment also provides that extended reporting period options are not required to be offered if a policy is cancelled for nonpayment of premium or a material misrepresentation or fraud, so long as this is stated in the policy.

The amendment to Section 365:15-1-18 removes the reference to the State Board of Property and Casualty Rates and replaces it with the Rate and Form Compliance Division of the Insurance Department. The amendment also adds transferring policyholders between admitted companies within the same insurance holding company system to the provisions relating to withdrawal or discontinuation of writing insurance and provides that the ninety (90) days notice period is inclusive of any other notice requirement per line of business. The amendment also requires insurers transferring policyholders to provide the date the insurer will transfer policyholders.

Section 365:15-1-22 is being revoked because of the online availability of the Affidavit of Exempt Status. As a result of online availability, the printing and mailing provision has made collection of the minimal fee more costly than originally intended by the rule.

The amendment to Section 365:15-7-3 removes a subsection exempting filing fees for certain transactions, such as error corrections since all filings are required to be submitted electronically and exempting these filing fees is unnecessary. The amendment also formalizes a bulletin that was previously issued by the Insurance Department by requiring electronic filings through the System for Electronic Rate and Form Filing (SERFF) pursuant to SERFF General Instructions. The amendment changes the requirement for filing two (2) copies with the Insurance Department to filing one (1) copy. Notices of action taken by the Insurance Commissioner shall also be through the SERFF.

The amendment to Section 365:15-7-16 clarifies existing statutes in Title 36 of the Oklahoma Statutes and existing regulations pertaining to statistical plans and statistical agents.

The amendment to Section 365:15-7-31 removes the reference to the State Board of Property and Casualty Rates and replaces it with the Rate and Form Compliance Division of the Insurance Department. The amendment also adds transferring policyholders between admitted companies within the same insurance holding company system to the provisions relating to withdrawal or discontinuation of writing insurance and provides that the ninety (90) days notice period is inclusive of any other notice requirement per line of business.

The amendment to Section 365:15-7-32 clarifies the application of the rules and that "a" rate filings are still use and file rather than prior approval. The amendment also requires that the justification statement be filed within thirty (30) days of the use of the rule and rate.

The amendment to Section 365:15-9-3 removes unnecessary language due to existing statutory language in Section 6821(C) of Title 36 of the Oklahoma Statutes.

The amendment to Section 365:15-9-10 removes a subsection exempting filing fees for certain transactions, such as error corrections since all filings are required to be submitted electronically and exempting these filing fees is unnecessary. The amendment also formalizes a bulletin that was previously issued by the Insurance Department by requiring electronic filings through the System for Electronic Rate and Form Filing (SERFF) pursuant to SERFF General Instructions. The amendment changes the requirement for filing two (2) copies with the Insurance Department to filing one (1) copy. Notices of action taken by the Insurance Commissioner shall also be through the SERFF.

The amendment to Section 365:15-9-18 clarifies existing statutes in Title 36 of the Oklahoma Statutes and existing regulations pertaining to statistical plans and statistical agents.

The new Section 365:15-9-22 adds provisions regarding the withdrawal or discontinue writing of medical malpractice insurance or programs in Oklahoma. This new section requires medical malpractice insurance carriers to notify the Insurance Department so that the Insurance Department may monitory which companies within the state are currently offering medical malpractice coverage.

Appendix D is being revoked and reenacted to reflect that approvals of increases must be on a percentage basis rather than seeking approvals based on a rate change and to reflect that the form should be submitted to the Rate and Form Compliance Division of the Insurance Department.

CONTACT PERSON:
Melanie Pouncey Sullivan, Assistant General Counsel, Oklahoma Insurance Department, 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112, (405) 521-2749

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 14, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

365:15-1-3. Property and casualty form filings

(a) **Purpose.** The purpose of this section is to specify the procedures for submitting form filings to the Insurance Commissioner as required by Article 36 of the Insurance Code.

(b) **Procedures.** Policy forms, endorsements and revisions thereto, by insurance companies and advisory organizations licensed in Oklahoma, shall be submitted in compliance with this section, or shall be rejected for filing, and the entity that made such submission shall be so notified.

(1) **Filing requirements.** The Insurance Code, Article 36, requires that each insurer shall make its form filings by line of business directly with the Insurance Commissioner. Companies may satisfy their obligation to make such filings, where authorized by law, by becoming a member or subscriber to an Oklahoma licensed advisory organization that makes such filings.

(2) **Filing fees.**

(A) Form filings shall be accompanied by the proper fees as specified in the Insurance Code. Fees shall not be paid in cash.

(B) Filings for groups of insurers shall be accompanied by the specified fee for each transaction, regardless of the number of members or subscribers.

(C) Filings by advisory organizations shall be accompanied by the specified fee for each transaction regardless of the number of members or subscribers.

~~(D) Filing fees are not required for transactions that involve only the following:~~

~~(i) Error corrections.~~

~~(ii) Change in effective date for approved filing.~~

~~(iii) Final printing of approved forms.~~

~~(iv) Additional information or amendments to pending filings.~~

~~(v) Withdrawal of obsolete forms having no impact on Oklahoma policyholders.~~

~~(vi) Change in officer or signature for approved filing.~~

~~(vii) Change in company logo for approved filing.~~

~~(viii) Changing the effective date for advisory organization filings by members or subscribers.~~

(3) **Address requirements.** All filings shall be addressed as follows: Oklahoma Insurance Commissioner, P.O. Box 53408, Oklahoma City, OK 73152-3408.

(4) **Number of copies.** All filings except those exempted shall be submitted through the System for Electronic Rate and Form Filing (SERFF) pursuant to the SERFF General Instructions. All paper filings including the cover letter, all exhibits, forms and additional information submitted to the Insurance Commissioner shall be typewritten or printed and submitted with ~~two (2)~~ one (1) legible ~~copies~~ copy of all material. ~~Such filings and exhibits shall be typewritten or printed.~~ Companies that file as a group listing all companies on the transmittal letter may accomplish this requirement by submitting ~~two (2)~~ one (1) typewritten or printed legible ~~copies~~ copy of all material.

(5) **Effective date of filings.** The effective date of form filings and the dates of required action by the Insurance Commissioner are governed by the applicable provisions of the Insurance Code.

(6) **Notice of Insurance Commissioner action.** The Insurance Commissioner shall indicate action taken ~~in writing, one (1) copy of which shall be attached to the official file copy and one (1) copy transmitted to the filing entity, or action may be indicated by stamp, with the individual stamping same, placing his initial or signature thereunder. Responses to questions shall be submitted in writing with two legible copies of all material~~ through the System for Electronic Rate and Form Filing (SERFF). Nothing in this section shall preclude the Insurance Commissioner from the use of other forms of communication to secure information from the filing entity.

(7) **Life, accident and health insurance.** This section does not apply to Life, Accident and Health. Life, Accident and Health filings shall be made in accordance with the applicable provisions of the Insurance Code and Rules of the Insurance Commissioner.

(8) **Postage requirements.** No submissions shall be accepted which arrive at the offices with postage due. No submissions will be returned unless the necessary postage accompanies the same.

(9) **Filing form and content.** All filings shall contain the following:

(A) The name of the filing entity and complete mailing address to which correspondence shall be sent.

(B) A "RE" or "caption" briefly describing the content and context of the filing.

(C) A list or index of the forms filed in the filing letter or attached thereto including the form numbers and edition date, if applicable.

(D) A complete description and full explanation of the changes made by the filing including, reasoning therefore, illustrative examples, including "John Doe" specimen form, and a comparison of currently approved and proposed materials (side by side comparison or marked copy).

(E) A concise statement to identify the form to be replaced by the filing including the approval date in this jurisdiction and the identifying filing number of the filing containing the form to be replaced as assigned by the Insurance Department.

(F) If a form is being withdrawn or amended due to court decisions in any jurisdiction, the filing entity shall furnish the legal citation, and if from another jurisdiction, a copy of such decision or opinion with its filing.

(G) If a form filing is due to a federal law or regulation of a federal agency, the filing entity shall furnish the legal citation and a copy of the pertinent provisions.

(H) Completed transmittal forms and exhibits.

(10) **Withdrawal of pending filings.** Pending filings may be withdrawn by the filing entity upon notice to the Insurance Commissioner prior to the approval or disapproval thereof. The notice shall include the reason for the withdrawal.

(11) **Duration of filings.** All filings are in effect until withdrawn or amended by the insurer or rating organization, with approval of the Insurance Commissioner or until abrogated by the Insurance Commissioner.

(12) **Advisory organization deviations.** Every member of, or subscriber to, a licensed rating organization may adhere to any filings made on its behalf by its Advisory Organization, except that any such member or subscriber may deviate from such filings as authorized by this section if it has filed with the Advisory Organization and with the Insurance Commissioner, the deviation to be applied and information necessary to justify the deviation. If such deviation is approved, it shall remain in force until such approval is withdrawn or replaced by the insurer with approval of the Insurance Commissioner.

(13) **Group filings.** Where filings are made on behalf of more than one insurer, the filing shall list the insurer or insurers by individual name and not by Company group.

(14) **Members of or subscribers to a licensed advisory organization.**

(A) **Filings.** A licensed advisory organization may make filings on behalf of its members and subscribers except deviation filings.

(B) **Adherence to filings.** Every member of or subscriber to a licensed advisory organization may adhere to any filings made on its behalf by such organization except that any such member or subscriber may deviate from such filings upon compliance with this section and approval of the Insurance Commissioner

(C) **Individual company filings.** Members and subscribers shall not file individual forms that have been filed on their behalf by the appropriate advisory organization. Declaration pages, policy "jackets" and other forms not normally filed by the rating organization shall be filed by the insurer directly with the Insurance Commissioner.

(D) **Filing requirements; advisory organization form deviation.** If form deviations are proposed, the insurer shall file the form including supporting documentation with the Insurance Commissioner and furnish copies to the appropriate rating organization.

(E) **Agency filings.** "Agency Filings" by a Rating Organization on behalf of its members or subscribers shall be accepted by the Insurance Commissioner in instances where the rating organization does not have a filing in effect for the coverage involved.

(15) **Independent filings.** If the insurer is filing an independently developed form, the filing shall comply with the following:

(A) File Policy Forms, Endorsements, and other materials, with the Insurance Commissioner and designate them as "Independent Filings".

(B) File support of each filing in accordance with this section.

(C) For revisions, file form with the Insurance Commissioner.

(16) **Reference filings.**

(A) **Advisory Organization Filings.**

(i) **Filings permitted without reference filing agreement.** Advisory Organization forms used in whole or in part may be adopted by <u>participating insurers of a licensed advisory organization by</u> "Reference Filings" subject to the approval of the Insurance Commissioner. When making such type filing submit a filing memorandum identifying the forms used. Departures and exceptions, if any, shall be accompanied by the necessary supporting data. Such adoption shall apply only to current filings and shall have no automatic effect as to future filings. Each advisory organization filing shall be separately and specifically adopted.

(ii) **Filings permitted with reference filing agreement.** Approved Advisory Organization material may be adopted by <u>participating insurers of a licensed advisory organization by</u> filing a REFERENCE FILING AGREEMENT with the Insurance Commissioner identifying the forms and material to be used. Such adoption shall apply from the date it is approved by the Insurance Commissioner to filings in effect on that date and to all applicable future filings. It shall remain in effect until such time as the agreement is withdrawn with the approval of the Commissioner.

(iii) **Reference filing.** If filing by "Reference Filing" DO NOT file forms.

(B) **Other than Advisory Organization filings.** An insurer may adopt another insurer's filing by filing forms on the filing insurer's format and by advising the Insurance Commissioner of the names(s) of the insurer whose program is being copied, the Oklahoma filing number, and the date(s) the program was filed for that insurer. Unless an exception is granted by the Insurance Commissioner, this procedure applies only to the filing of the initial program for the adopting insurer and is subject to the review of the Insurance Commissioner.

(17) **Resubmittal of filings.** All resubmissions of disapproved or rejected filings shall be presented to the Insurance Commissioner in the same manner as required by this section for an original filing. In addition the cover letter or completed transmittal forms addressed to the Insurance Commissioner shall state the full and complete history of the filing, the reason for disapproval or rejection, and the factors which distinguish the resubmittal so it warrants reconsideration.

(18) **Retroactive filings.** The Insurance Commissioner has no authority to and shall not approve filings proposing a retroactive effective date except in cases of a filing correcting an error in a previously approved filing and in cases where required or necessitated by Statute.

(19) **Delivery of policy to insured.** In any instance whereby a policy of insurance is effected the insured shall be furnished with either:

(A) The original policy;

(B) A copy of the original policy or a duplicate policy printed with ten point or larger type; or

(C) A certificate including provisions and conditions of the original policy printed with ten point or larger type.

(20) **Coverage elimination after policy issuance.** Any endorsement which eliminates or restricts coverage and which is issued during the policy term shall be identified as accepted by the insured, by the signature of the insured thereon, and a signed copy (original, computer generated or microfilm) of such endorsement shall be retained in the files of the insurer for one year after the expiration of the policy.

(21) **Uniform standard mortgage clause.** The mortgage clause to be used by Insurance Companies in Oklahoma shall be uniform Standard Form Number 127B September 1934 Edition or subsequent editions, except upon written application by an insurer or rating organization, a ~~cause~~ clause providing broader coverage may be approved by the Insurance Commissioner.

(22) **Claims-made policies.**

(A) The policy application and the Declarations page of each claims-made policy shall include a conspicuous notice indicating that the contract is a claims-made policy and advising the policyholder to read its provisions.

(B) The policy shall provide for extended reporting period options based on rules, rates or rating plans approved by the Insurance Commissioner. If so stated in the policy, the extended reporting period options shall not be required to be offered if a policy is cancelled for nonpayment of premium or a material representation or fraud.

(23) **New forms, reductions in coverage.**

(A) Form filings that may result in the elimination of claims (losses) shall be considered as a relevant factor to be given due consideration by the Insurance Commissioner as respects rates in effect or proposed for the coverage involved.

(B) The filer shall fully disclose the rate consideration so that Commissioner can be notified of the form filing. The form filing may be disapproved if the rate effect has not been considered in rules, rates or rating plans approved by or filed with the Commissioner.

365:15-1-18. Withdrawal or discontinue writing

~~(a)~~ Any insurer desiring to withdraw from the state or discontinue the writing of certain classes of insurance or programs in this state or transferring policyholders between admitted companies within the same insurance holding company system shall give ninety (90) days notice in writing to the ~~Property and Casualty~~ Rate and Form Compliance Division of the Insurance Department and shall state in writing its reasons for such action. The ninety (90) days notice is inclusive of, and not in addition to, any other notice requirement per line of business. The insurer shall also provide the following information:

(1) The number of policyholders ~~effected~~ affected;

(2) The number of insurance agents ~~effected~~ affected;

(3) The date the insurer will cease writing new business;

(4) The date the insurer will start non-renewing insurance policies;

(5) The date the insurer will transfer policyholders;

(6) Whether the insurer has made arrangements with another insurer to pick up the renewals; if applicable;

(~~6~~ 7) The lines of insurance on which the insurer plans to concentrate; and

(~~7~~ 8) Whether the insurer anticipates re-entering the market.

365:15-1-22. Processing Fee for Affidavit of Exempt Status [REVOKED]

~~Pursuant to 36 O.S. § 924.4, the Insurance Department shall collect a non-refundable fee of Two Dollars and Fifty Cents ($2.50) for printing and mailing the blank Affidavit of Exempt Status form to persons who request it. Payment shall not be in cash.~~

SUBCHAPTER 7. PROPERTY AND CASUALTY COMPETITIVE LOSS COST RATING REGULATION

365:15-7-3. Property and casualty rate, loss cost and manual rule filings

(a) **Purpose.** The purpose of this section is to specify the procedures for submitting rate, loss cost and manual rule filings to the Insurance Commissioner as required by 36 O.S. § 981 et seq.

(b) **Procedures.** Rate, loss cost and manual rules and revisions thereto by insurance companies and advisory organizations licensed in Oklahoma shall be submitted in compliance with this section, or shall be rejected for filing, and the entity that made such submission shall be so notified.

(1) **Filing requirements.** The Insurance Code, 36 O.S. § 981 et seq., requires that each insurer shall make its rate, loss cost and manual rule filings by line of business directly with the Insurance Commissioner. Companies may satisfy their obligation to make such filings, where authorized by law, by becoming a member or subscriber to an Oklahoma licensed advisory organization which makes such filings.

(2) **Filing fees.**

(A) Rate, loss cost and manual rule filings shall be accompanied by the proper fees as specified in the Insurance Code. Fees shall not be paid in cash.

(B) Filings for groups of insurers shall be accompanied by the specified fee for each transaction regardless of the number of members or subscribers.

(C) Filings by advisory organizations shall be accompanied by the specified fee for each transaction regardless of the number of members or subscribers.

~~(D) Filing fees are not required for transactions that involve only the following:~~

~~(i) Error corrections;~~

~~(ii) Change in effective date for approved filing;~~

~~(iii) Final printed materials;~~

~~(iv) Additional information or amendments to pending filings;~~

~~(v) Withdrawal of obsolete filings having no impact on Oklahoma policyholders;~~

~~(vi) Excess consent rate filings;~~

~~(vii) Individual risk submissions;~~

~~(viii) Individual risk filings for excess workers' compensation;~~

~~(ix) Dividend plans; and or~~

~~(x) Changing the effective date for advisory organization filings by members or subscribers.~~

(3) **Address requirements.** All filings shall be addressed as follows: Oklahoma Insurance Commissioner, P.O. Box 53408, Oklahoma City, OK 73152-3408.

(4) **Number of copies.** All filings except those exempted shall be submitted through the System for Electronic Rate and Form Filing (SERFF) pursuant to the SERFF General Instructions. All paper filings including the cover letter, all exhibits, rate sheets and additional information submitted to the Insurance Commissioner shall be typewritten or printed and submitted with ~~two (2)~~ one (1) legible ~~copies~~ copy of all material. ~~Such filings and exhibits shall be typewritten or printed.~~ Companies that file as a group listing all companies on the transmittal letter may accomplish this requirement by submitting ~~two (2)~~ one (1) typewritten or printed legible ~~copies~~ copy of all material.

(5) **Effective date of filings.** The effective date of rate, loss cost and manual rule filings and the dates of required action by the Insurance Commissioner are governed by the applicable provisions of the Insurance Code.

(6) **Notice of Insurance Commissioner action.** The Insurance Commissioner shall indicate action taken ~~in writing, one (1) copy of which shall be attached to the official file copy and one (1) copy transmitted to the filing entity, or action may be indicated by stamp, with the individual stamping same, placing their initial or signature thereunder. Responses to questions shall be submitted in writing two legible copies of all material~~ through the System for Electronic Rate and Form Filing (SERFF). Nothing in this section shall preclude the Insurance Commissioner from the use of other forms of communication to secure information from the filing entity.

(7) **Life, accident and health insurance.** This section does not apply to life, accident and health insurance. Life, accident and health insurance filings shall be made in accordance with the applicable provisions of the Insurance Code and Rules of the Insurance Commissioner.

(8) **Postage requirements.** No submissions shall be accepted that arrive at the offices with postage due. No submissions will be returned unless the necessary postage accompanies the same.

(9) **Withdrawal of pending filings.** Pending filings may be withdrawn by the filing entity upon notice to the Insurance Commissioner prior to the approval or disapproval thereof. The notice shall include the reason for the withdrawal.

(10) **Filing form and content.** All filings shall include the following:

(A) The name of the filing entity and complete mailing address to which correspondence shall be sent.

(B) A "RE" or "caption" briefly describing the content and context of the filing.

(C) A list or index of the manual pages filed in the filing letter or attached thereto including the page numbers and edition date, if applicable.

(D) A complete description and full explanation of the changes made by the filing including, reasoning therefore, illustrative examples, including "John Doe" specimen examples, and a comparison of currently approved and proposed materials (side by side comparison or marked copy).

(E) A concise statement to identify the manual pages (rate and/or rule) to be replaced by the filing including the approval date in this jurisdiction and the identifying Oklahoma Insurance Department's assigned filing number of the filing containing the documents to be replaced .

(F) Completed transmittal forms and exhibits.

(11) **Advisory organization deviations.** Every member of, or subscriber to, a licensed advisory organization may adhere to any filings made on its behalf by its advisory organization, except that any such member or subscriber may deviate from such filings as authorized by this section if it has filed with the advisory organization and with the Insurance Commissioner, the deviation to be applied and information necessary to justify the deviation. If such deviation is approved, it shall remain in force until such approval is withdrawn by the insurer with approval of the Insurance Commissioner.

365:15-7-16. Statistical plans

~~(a) The Insurance Commissioner may approve a statistical plan or any modification thereto submitted by an insurer or advisory organization adapted to the applicable rating system, which shall be used thereafter for the recording of loss and expense experience.~~

(a) Every insurer doing business in this state shall file a statistical plan and any modifications thereto with the Oklahoma Insurance Department.

(b) The statistical plan shall record the loss and expense experience of the insurer and shall provide all data elements necessary to support the rating systems the insurer has filed with

the Oklahoma Insurance Department. The experience developed in accordance with an approved statistical plan shall be filed on a yearly basis.

(c) An insurer may appoint a registered advisory organization as its agent to report and file its statistical plan and experience.

(~~b~~ d) The Insurance Commissioner may approve an advisory organization as ~~his~~ a statistical agent to gather, record, compile and report experience in such manner, form and detail as determined by the Insurance Commissioner to be necessary to determine whether rating systems comply with the standards of the Property and Casualty Competitive Loss Cost Rating Act.

365:15-7-31. Withdrawal or Discontinue Writing

Any insurer desiring to withdraw from the state or discontinue the writing of certain classes of insurance or programs in this state or transferring policyholders between admitted companies within the same insurance holding company system shall give ninety (90) days notice in writing to the Insurance Department ~~Property and Casualty~~ Rate and Form Compliance Division. The insurer shall state in writing its reasons for such action. The ninety (90) day notice is inclusive of, and not in addition to, any other notice requirement per line of business. The insurer shall also provide the following information:

(1) The number of policyholders ~~effected~~ affected;

(2) The number of insurance agents ~~effected~~ affected;

(3) The date the insurer will cease writing new business;

(4) The date the insurer will start non-renewing insurance policies;

(5) Whether the insurer has made arrangements with another insurer to cover the renewals;

(6) The lines of insurance on which the insurer plans to concentrate; and

(7) Whether the insurer anticipates re-entering the market.

365:15-7-32. Use of "a" rates

(a) As used in Section 997 of Title 36 of the ~~laws of this state~~ Oklahoma Statutes, an "a" rate is a rating rule or rate expressed as the symbol "a" or the words "refer to company" listed opposite a classification code on the manual rule and rate pages.

(1) An insurer may not use an "a" rate ~~may be used only when neither an~~ if any advisory organization ~~nor~~ or any other insurer has ~~yet~~ established a manual rate based upon experience for the coverage.

(2) Once an advisory organization or ~~an~~ any insurer acquires sufficient experience to establish a manual rate for such coverage, then the coverage is no longer considered to be eligible for "a" rating.

(b) An insurer claiming an "a" rate exemption ~~pursuant to Section 997 of Title 36 of the laws of this state~~ shall file with the Commissioner a statement justifying the use of the exemption. The statement shall include the policies and procedures for underwriting and developing "a" rates and any formal guidelines established by the insurer for these situations. The filing shall include an acknowledgment that the coverage is no longer eligible for "a" rating once an advisory organization or an insurer acquires sufficient experience to establish a manual rate for such coverage. The justification statement shall be filed within thirty (30) days of the use of the rule and rate.

SUBCHAPTER 9. MEDICAL PROFESSIONAL LIABILITY RATE SETTING

365:15-9-3. Notice to Policyholders

~~(a) The Commissioner may direct in writing that the medical professional liability insurer filing a rate change application provide the notification to policyholders required pursuant to Section 6821(C) of Title 36. Upon notification to the policyholders as directed by the Commissioner, the Commissioner may direct that the medical professional liability insurer deliver to the Insurance Department an affidavit executed by an officer of the insurer attesting that said notification has been provided to its policyholders.~~

(~~b~~ a) Notification to policyholders required pursuant to Section 6821(C) of Title 36 shall be in the form as set out in Appendix D of this Chapter.

(~~c~~ b) Policyholders who are notified of any application for a rate change and the medical malpractice liability insurer making the application for a rate change may submit to the Insurance Commissioner a letter signed by the policyholder waiving the right to request a rate change application hearing pursuant to 36 O.S. § 6821(C)(1).

365:15-9-10. Property and casualty rate, loss cost and manual rule filings

(a) **Purpose.** The purpose of this section is to specify the procedures for submitting rate, loss costs and manual rule filings to the Insurance Commissioner, which are submitted under the authority of 36 O.S. § 6821.

(b) **Procedures.** Rate, loss costs and manual rules and revisions by insurance companies and advisory organizations licensed in Oklahoma shall be submitted in compliance with this section or shall be rejected for filing. If a filing is rejected, the entity that made such submission shall be notified.

(1) **Filing requirements.** The rate, loss cost and manual rule filings allowed by this section are for medical professional liability insurance. Companies may satisfy their obligation to make such filings, where authorized by law, by becoming a member or subscriber to an Oklahoma licensed advisory organization which makes such filings.

(2) **Filing fees.**

(A) Rate, loss cost and manual rule filings shall be accompanied by the proper fees as specified in the Insurance Code. Fees shall not be paid in cash.

(B) Filings for groups of insurers shall be accompanied by the specified fee for each transaction regardless of the number of members or subscribers.

(C) Filings by rating organizations shall be accompanied by the specified fee for each transaction regardless of the number of members or subscribers.

~~(D) Filing fees are not required for transactions that only involve the following:~~

~~(i) Changing the effective date for advisory organization filings by members or subscribers;~~

~~(ii) Additional information or amendments to pending filings;~~

~~(iii) Advising the Insurance Department of the effective date for an approved filing and/or submitting final printed materials;~~

~~(iv) Dividend plans;~~

~~(v) Withdrawal of obsolete filings having no impact on Oklahoma policyholders.~~

(3) **Address requirements.** All filings shall be addressed as follows: Oklahoma Insurance Commissioner, P.O. Box 53408, Oklahoma City, OK 73152-3408.

(4) **Number of copies.** All filings except those exempted shall be submitted through the System for Electronic Rate and Form Filing (SERFF) pursuant to SERFF General Instructions. All paper filings including the cover letter, all exhibits, rate sheets and additional information submitted to the Insurance Commissioner shall be submitted with ~~two (2)~~ one (1) legible ~~copies~~ copy of all material. ~~Such filings and exhibits shall be typewritten or printed.~~ Companies that file as a group and list all companies on the transmittal letter may accomplish this requirement by submitting ~~two (2)~~ one (1) typewritten or printed legible ~~copies~~ copy of all material. .

(5) **Effective date of filings.** The effective date of rate, loss cost and manual rule filings and the dates of required action by the Insurance Commissioner are governed by the applicable provisions of the Insurance Code.

(6) **Notice of Insurance Commissioner action.** The Insurance Commissioner shall indicate action taken ~~in writing, one (1) copy of which shall be attached to the official file copy and one (1) copy transmitted to the filing entity. Action may also be indicated by stamp, with the individual stamping their initial or signature thereunder. Responses to questions shall be submitted in writing with two legible copies of all material~~ through the System for Electronic Rate and Form Filing (SERFF). Nothing in this section shall preclude the Insurance Commissioner from the use of other forms of communication to secure information from the filing entity.

(7) **Life, accident and health insurance.** This section does not apply to life, accident and health insurance. Life, accident and health insurance filings shall be made in accordance with the applicable provisions of the Insurance Code and Rules of the Insurance Commissioner.

(8) **Postage requirements.** No submissions shall be accepted that arrive at the offices with postage due. No submissions will be returned unless the necessary postage accompanies the same.

(9) **Withdrawal of pending filings.** Pending filings may be withdrawn by the filing entity upon notice to the Insurance Commissioner prior to the approval or disapproval thereof. The notice shall include the reason for the withdrawal.

(10) **Filing form and content.** All filings shall include the following:

(A) The name of the filing entity and complete mailing address to which correspondence shall be sent.

(B) A RE or caption briefly describing the content and context of the filing.

(C) A list or index of the manual pages filed in the filing letter or attached thereto including the page numbers and edition date, if applicable.

(D) A complete description and full explanation of the changes made by the filing including reasoning therefor, illustrative examples, including John Doe specimen examples, and a comparison of currently approved and proposed materials (side by side comparison).

(E) A concise statement identifying the manual pages (rate and or rule) to be replaced by the filing. The statement shall include the approval date in this jurisdiction and the identifying Oklahoma Insurance Department's assigned filing number of the filing containing the documents to be replaced .

(F) Completed transmittal forms and exhibits.

(11) **Bureau deviations.** Every member of, or subscriber to, a licensed advisory organization may adhere to any filings made on its behalf by its rating organization, except that any such member or subscriber may deviate from such filings as authorized by this section if it has filed with the rating organization and with the Insurance Commissioner, the deviation to be applied and information necessary to justify the deviation. If such deviation is approved, it shall remain in force until such approval is withdrawn by the insurer with approval of the Insurance Commissioner.

365:15-9-18. Statistical plans

~~(a) The Insurance Commissioner may approve a statistical plan or any modification to the plan submitted by an advisory organization adapted to the applicable rating system, which shall be used thereafter for the recording of loss and expense experience.~~

(a) Every insurer doing business in this state shall file a statistical plan and any modifications thereto with the Oklahoma Insurance Department.

(b) The statistical plan shall record the loss and expense experience of the insurer and shall provide all data elements necessary to support the rating systems the insurer has filed with the Oklahoma Insurance Department. The experience developed in accordance with an approved statistical plan shall be filed on a yearly basis.

(c) An insurer may appoint a registered advisory organization as its agent to report and file its statistical plan and experience.

(~~b~~ d) The Insurance Commissioner may approve an advisory organization as ~~the~~ a statistical agent to gather, record, compile, and report experience in such manner, form, and detail determined by the Insurance Commissioner as necessary to ~~ascertain~~ determine whether rating systems comply with the

standards of the ~~applicable provisions of the Insurance Code~~ Property and Casualty Competitive Loss Cost Rating Act and Section 6821 of Title 36 of the Oklahoma Statutes.

365:15-9-22. Withdrawal or discontinue writing

Any insurer desiring to withdraw from the state or discontinue the writing of medical malpractice insurance or programs in this state or transferring policyholders between admitted companies within the same insurance holding company system shall give ninety (90) days notice in writing to the Rate and Form Compliance Division of the Insurance Department. The insurer shall state in writing its reasons for such action. The ninety (90) day notice is inclusive of, and not in addition to, any other notice requirement per line of business. The insurer shall also provide the following information:

(1) The number of policyholders affected;
(2) The number of insurance agents affected;
(3) The date the insurer will cease writing new business;
(4) The date the insurer will start non-renewing insurance policies;
(5) Whether the insurer has made arrangements with another insurer to cover the renewals;
(6) The lines of insurance on which the insurer plans to concentrate; and
(7) Whether the insurer anticipates re-entering the market.

APPENDIX D. FORMAT FOR NOTIFICATION TO POLICYHOLDERS OF APPLICATION FOR RATE CHANGE [REVOKED]

APPENDIX D. FORMAT FOR NOTIFICATION TO POLICYHOLDERS OF APPLICATION FOR RATE CHANGE [NEW]

NOTICE OF RATE CHANGE APPLICATION

TO ALL INSUREDS OF [medical professional liability insurer name]

On [rate change application filing date], [medical professional liability insurer name] filed a Rate Change Application with the Oklahoma Insurance Department, seeking approval of a percentage increase change in its medical professional liability rates. The proposed effective date of this rate change will be [effective date]. Policyholders are entitled to notice of the Rate Change Application pursuant to Section 6821(C) of Title 36 of the Oklahoma Insurance Code.

[Medical professional liability insurer name] has the burden of proving that the requested change is justified and meets the requirements of Section 6821. You or your representative may request a hearing by the Oklahoma Insurance Department on the Application. The hearing request must be in writing and must be received by the Insurance Department within forty-five (45) days of the date of this notice. Requests for a hearing must be addressed to the Oklahoma Insurance Department, Attn: Property and Casualty Division, P. O. Box 53408, Oklahoma City, OK 73152-3408. The scope of the hearing will be limited to the items mentioned by Section 6821. Written requests for a hearing and written comments about the proposed change become public record and are subject to the Oklahoma Open Records Act.

No professional medical liability insurer shall cancel or refuse to renew coverage of a policyholder on the basis of a policyholder's exercise of any right pursuant to Section 6821.

Specific questions about the circumstances that produced the Rate Change Application should be directed to [medical professional liability insurer contact person, contact information]. Questions about the details of the Application should be directed to the Rate and Form Compliance Division of the Oklahoma Insurance Department.

Sincerely,

[medical professional liability insurer contact information].

[OAR Docket #10-755; filed 5-4-10]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 25. LICENSURE OF PRODUCERS, ADJUSTERS, BAIL BONDSMEN, COMPANIES, PREPAID FUNERAL BENEFITS, AND VIATICAL SETTLEMENTS PROVIDERS AND BROKERS

[OAR Docket #10-756]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 3. Producers, Brokers, Limited Lines Producers and Vehicle Protection Product Warrantors
365:25-3-1.2. Provisional producer licensees [AMENDED]
365:25-3-14. Insurance adjusters continuing education [AMENDED]
365:25-3-15. Variable annuity licensing [AMENDED]
365:25-3-16. Examination exemptions [AMENDED]
365:25-3-21. Training and education requirements for the sale of annuities [NEW]
Subchapter 5. Bail Bondsmen
Part 5. General Provisions Pertaining to Bail Bondsmen
365:25-5-39. Affidavit as to undertaking [AMENDED]
365:25-5-40. Computation of time in 59 O.S. § 1332 [AMENDED]
365:25-5-44. Notice of return to custody [NEW]
Part 7. Specific Financial Circumstances Warranting Release of Professional Deposit [NEW]
365:25-5-50. Authority and scope [NEW]
365:25-5-51. Specific financial circumstances enumerated [NEW]
365:25-5-52. Time governing release of professional deposit [NEW]
365:25-5-53. Limitations upon release of professional deposit below applicable limits [NEW]
365:25-5-54. Review of bail bondsmen's administrative history before release of professional deposit [NEW]
365:25-5-55. Denial of request if bail bondsman has prior forfeitures [NEW]
365:25-5-56. Limits on outstanding liabilities [NEW]
365: 25-5-57. Commissioner discretion to release amount less than requested [NEW]
365:25-5-58. Approval of final order by Commissioner [NEW]
Subchapter 9. Prepaid Funeral Benefits
365:25-9-3. Forms [AMENDED]
Appendix C. Application for Original Permit [NEW]
Appendix M. Application for Renewal of Permit [NEW]
Appendix X. Sellers Notice to the Insurance Commissioner [NEW]
Appendix Y. Assumption Affidavit [NEW]
AUTHORITY:
Insurance Commissioner, 36 O.S. §§ 307.1, 1435.19, 1435.29(H), and 6123; 59 O.S. §§ 1302(A) and 1306(A)(5).
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Superseded rules:
Subchapter 3. Producers, Brokers, Limited Lines Producers and Vehicle Protection Product Warrantors
365:25-3-14. Insurance adjusters continuing education [AMENDED]
Subchapter 5. Bail Bondsmen
Part 7. Specific Financial Circumstances Warranting Release of Professional Deposit [NEW]
365:25-5-50. Authority and scope [NEW]
365:25-5-51. Specific financial circumstances enumerated [NEW]
365:25-5-52. Time governing release of professional deposit [NEW]
365:25-5-53. Limitations upon release of professional deposit below applicable limits [NEW]
365:25-5-54. Review of bail bondsmen's administrative history before release of professional deposit [NEW]
365:25-5-55. Denial of request if bail bondsman has prior forfeitures [NEW]
365: 25-5-56. Limits on outstanding liabilities [NEW]
365: 25-5-57. Commissioner discretion to release amount less than requested [NEW]
365: 25-5-58. Approval of final order by Commissioner [NEW]
Subchapter 9. Prepaid Funeral Benefits
365:25-9-3. Forms [AMENDED]
Appendix C. Application For Original Permit [NEW]
Appendix M. Application for Renewal of Permit [NEW]
Appendix X. Sellers Notice to the Insurance Commissioner [NEW]
Appendix Y. Assumption Affidavit [NEW]
Gubernatorial approval:
October 2, 2009
Register publication:
27 Ok Reg 165
Docket number:
09-1290
INCORPORATIONS BY REFERENCE:
n/a
ANALYSIS:

The amendment to Section 365:3-1.2 increases the number of provisional licensees that a producer may sponsor from five (5) to ten (10) provisional licensees per sponsoring producer.

The amendment to Section 365:25-3-14 sets forth continuing education requirements and requires at least two of the adjuster continuing education credit hours to be state or federal legislative updates. The amendment to Section 365:25-3-15 provides that applicants for a variable annuity license are required to provide proof of current FINRA registration with series 6 or 7 and series 63 or 66, and pay an additional fee for the variable license. Company endorsements are no longer required with submission of a variable annuity application. The addition to Section 365:25-3-16 exempts multi-peril crop adjusters certified by the Federal Risk Management Agency from licensure if working on, or on behalf of, the Federal Crop Insurance Corporation. New Section 365:25-3-21 requires producers to hold a Life line of Authority before selling, soliciting or negotiating annuities. In addition, the rule requires training for all producers who sell, solicit or negotiate annuities. The rule requires producers to complete a one-time, four (4) hour credit training course. The continuing education shall be completed within twelve (12) months after July 14, 2010 for current Life line of Authority holders and requires the training to be completed prior to issuance of a Life line of Authority for producers wishing to hold a Life line of Authority after July 14, 2010. The rule specifies the type of information to be included in the continuing education courses and requires verification that the producer completed the mandatory training. Finally, the rule provides for reciprocity regarding satisfaction of substantially similar training requirements of another state.

The amendment to Section 365:25-5-39 requires provisions regarding an Affidavit as to Undertaking to be mandatory rather than permissive so as to conform to mandatory language in 59 O.S. §1322. The amendment to Section 365:25-5-40 accommodates court clerks using electronic certified mail which has been introduced by the United States Postal Service and allows for certain dates of receipt to be evidenced electronically. The new Section 365:25-5-44 requires a bondsman to notify the court clerk of the county where the forfeiture occurred of the return of the defendant to custody for the purposes of maintaining an updated status of the case and allowing the clerk to monitor pending criminal cases falling under the disciplinary authority of the Oklahoma Insurance Department.

New Part 7 of Subchapter 5, Specific Financial Circumstances Warranting Release of Professional Deposit, establishes standards and guidelines for "the

specific circumstances" the Insurance Commissioner may consider when reviewing a professional bail bondsman's request for the partial release of deposit, as now allowed by amendments to Section 1306(A)(5) of Title 36 enacted in Senate Bill 406.

The amendment to Section 365:25-9-3 and new Appendices C, M, X and Y incorporate statutory changes, re-enact new versions of the revoked forms and add newly created forms as prescribed by Senate Bill 1231 which increases the background information, including requiring biographies from all parties seeking a Prepaid Funeral benefits permit, and provides that the process of assumption of a prepaid funeral trust will be more transparent and provide more information about the assumption process and the financial fitness and strength of purpose of the acquiring party.

CONTACT PERSON:

Melanie Pouncey Sullivan, Assistant General Counsel, Oklahoma Insurance Department, 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112, (405) 521-2749

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 14, 2010:

SUBCHAPTER 3. PRODUCERS, BROKERS, LIMITED LINES PRODUCERS AND VEHICLE PROTECTION PRODUCT WARRANTORS

365:25-3-1.2. Provisional producer licensees

(a) **Sponsoring producers.** A sponsoring producer may supervise no more than ~~five (5)~~ ten (10) provisional licensees at any time.

(b) **Pre-licensing education.** The Commissioner shall develop and publish the topic outlines covered in the eight (8) hours of pre-licensing education. Providers and course submissions shall be approved by the Commissioner in the same manner as applicable to continuing education courses. Course submission shall include all course materials. All courses shall be offered as classroom instruction.

(c) **Time requirements-exceptions.** A provisional producer license may be held for up to six (6) months to complete pre-licensing education requirements. A licensee who is unable to comply with pre-licensing education requirements due to military service, a medical condition, or other extenuating circumstance may request an extension of time to complete the requirements. The request shall be in writing.

365:25-3-14. Insurance adjusters continuing education

(a) **Purpose.** The purpose of this section is to set forth the requirements for continuing education which an insurance adjuster must meet, and to set forth the requirements for approval by the Insurance Commissioner of a proposed continuing education course.

(b) **Definitions.** The following words or terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"CEC"** means continuing education credit.

(2) **"Certificate of course completion"** means a document acceptable to the Commissioner which signifies satisfactory completion of the course and reflects hours of credit earned.

(3) **"Continuing Education Advisory Committee"** means the committee established by the Commissioner for the purpose of reviewing and recommending approval or disapproval of continuing education courses.

(4) **"Credit hour"** means at least fifty (50) minutes of classroom instruction, unless a correspondence or self-study course.

(5) **"Instructor"** means a person who presents course materials approved for continuing education credit hours, and who has experience, training, and/or education in the course subject matter and has been approved by the Commissioner.

(6) **"Instructor Qualification Form"** means a form acceptable to the Commissioner and completed by the instructor which documents qualifications of the instructor.

(7) **"Licensee"** means a natural person who is licensed by the Commissioner as an insurance adjuster.

(8) **"Provider"** means a person, corporation, professional association or its local affiliates, an insurance company or any other entity which is approved by the Commissioner and provides approved continuing education to insurance adjusters.

(9) **"Provider Course Completion Form"** means a form acceptable to the Commissioner and completed by the provider which documents completion of an approved course by an adjuster or adjusters.

(c) **Exceptions.** Continuing education requirements shall not apply to non-resident adjusters licensed in a state that has a continuing education requirement for adjusters.

(d) **Continuing education requirements.**

(1) **~~Twelve hours of~~ CEC during twenty-four month period.** ~~All licensees shall complete twelve (12) credit hours of continuing education during each twenty-four month period.~~ All licensees shall complete the required hours of continuing education as set forth in Section 6217(B) of Title 36 of the laws of this state during each twenty-four month period. The twenty-four month period begins the first day of the month following the month in which the license is granted. The credit hours completed must be in those lines in which the adjuster is licensed. ~~Courses taken in excess of twelve (12) hours will not carry forward. However, courses taken in excess of twelve (12) hours may be applied retroactively in order to bring a lapsed license into compliance.~~ Six (6) credit hours in excess of the minimum twenty-four month period requirement shall carry forward to the next twenty-four month period. Excess hours may be applied to bring a lapsed license into compliance.

(2) **Certificates of course completion required for license renewal.** If course completion is not reflected on the license renewal form issued by the Insurance Department, each adjuster shall attach, if requested by the Commissioner, an approved course completion certificate to the license renewal form returned to the Department for verification of course completion. The Commissioner shall maintain a cumulative total of continuing education

credit hours to insure compliance within the twenty-four (24) month period.

(3) **Legislative Updates.** At least two (2) of the continuing education credit hours of instruction completed by licensees each twenty-four month period shall be taken in the following topics:

(A) State legislative updates, or

(B) Federal legislative updates.

(~~3~~4) **Credits for instructors.** An instructor who is a licensee shall receive the same continuing education credit for presenting approved course materials as a licensee who attends an approved classroom instructional session by including his/her name and license number on roster.

(~~4~~5) **Prerequisite for renewal or reinstatement.** As a prerequisite for license renewal or prior to reinstatement following a lapse of license, an adjuster must submit the appropriate forms as specified in this section that establish the educational requirements have been met if not currently recorded by the Oklahoma Insurance Department.

(e) **Approval of continuing education providers.**

(1) **Information required.** Each provider shall apply for approval by the Commissioner. All providers, including publicly funded educational institutions, federal agencies, or Oklahoma state agencies, shall provide:

(A) Name and address of the provider.

(B) Contact person and his or her address and telephone number(s).

(C) The location of the courses or programs, if known, unless it is an individual elf-study course.

(D) The number of CEC hours requested for each course.

(E) Topic outlines which list the summarized topics covered in each course and a copy of any course materials.

(F) The names and qualification of instructors. An instructor shall have one of the following qualifications:

(i) Three (3) years of recent experience in the subject area being taught; or

(ii) A degree related to the subject area being taught; or

(iii) Two (2) years of recent experience in the subject area being taught and twelve (12) hours of college and/or vocational technical school credit hours in the subject area being taught.

(G) If a prior approved course has materially changed, a summarization of those changes.

(2) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval of any provider for violation of or non-compliance with any provision of this section.

(f) **Courses; approval; records.**

(1) **Course approval timeline.** A provider shall apply to the Commissioner for course approval by submitting forms and materials to the Commissioner the first day of the month one full month prior to the date of the first course offering. The Commissioner shall grant or deny approval based upon information submitted in this section regarding each course or additional information regarding the course, if necessary. The Commissioner will assign the number of CEC hours awarded for an approved course and the line or lines of insurance for which the course qualifies.

(2) **Repeated approved course.** At least fourteen (14) days prior to the repetition of an approved course, the Commissioner shall be notified in writing of the repetition, providing course number, name, date, location and instructor's name.

(3) **Written approval required.** All courses shall require written approval by the Commissioner.

(4) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval for any course. This withdrawal will not affect any CEC hours attained under the course previous to the withdrawal.

(5) **Minimum of one credit hour.** Courses submitted for approval must consist of a minimum of one credit hour of course instruction.

(6) **Continuing education course must be separate from meetings.** Courses conducted in conjunction with other meetings must have a separate continuing education course component.

(7) **Content of courses.** Courses must be of a meaningful nature and shall not include items such as prospecting, motivation, sales techniques, psychology, recruiting, time management, phone etiquette, basic pre-licensing principles of adjusting, and subjects not relating to the adjuster's license.

(8) **Certificate of Course Completion.** At the completion of each course, the provider shall provide the insurance adjuster a "Certificate of Course Completion" Form.

(9) **List of adjusters completing course to Commissioner.** Within ten (10) business days after completion of each course, the provider shall provide the Commissioner a list of all insurance adjusters who completed the course on the Course Completion Form. This list shall contain the course number, date of completion and license numbers of all insurance adjusters completing the course. If the list is not reported within ten (10) business days, a late report fee of $50.00 shall be paid to the Insurance Department. Failure to pay the late report fee may result in revocation of provider approval. Continued late filing may also result in loss of approval.

(10) **Course records maintained four (4) years.** Providers shall maintain course records for at least four (4) years. The Commissioner may order an examination of a provider, at the provider's expense, for good cause shown.

(11) **Course review fee.** A non-refundable course review fee of thirty dollars ($30.00) per course shall be submitted by all continuing education providers at the time the course submission is first submitted for review and upon submission for renewal at expiration with the exception of publicly funded educational institutions, federal agencies, Oklahoma state agencies, non-profit organizations, and not-for-profit organizations.

(g) **Approved professional designation programs.**

(1) **Definitions.**

(A) **Participation.** As used in 36 O.S. § 1435.29(B)(3), participates means successfully completing any part of a course curriculum totaling twenty (20) classroom or equivalent classroom hours of an approved professional designation program.

(B) **Approved professional designation program.** As used in 36 O.S. § 1435.29(B)(3), an approved professional designation program means an educational insurance program approved by the Commissioner with a sponsoring organization that administers curriculum requirements and testing standards for candidates.

(2) **Requirements.** A professional designation program shall satisfy the following criteria to receive initial and ongoing approval for the program:

(A) The program shall have a sponsoring organization;

(B) The program's sponsoring organization shall maintain and govern a code of conduct;

(C) The program shall be relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma;

(D) Each course of the professional designation course curriculum shall be a minimum of twenty (20) hours of classroom instruction or equivalent classroom instruction; and

(E) The program shall include an examination requirement that students shall pass before earning the designation.

(3) **Submissions.** The sponsoring organization shall submit the following to the Commissioner for its professional designation program to be considered for initial and ongoing approval for the program:

(A) The sponsoring organization's code of conduct;

(B) The sponsoring organization's membership requirements;

(C) The professional designation program's course requirements; and

(D) The professional designation program's examination requirements.

(4) **Submission exemptions.** Professional designation programs recognized by the National Association of Insurance Commissioners (NAIC) for waiver/exemption of pre-licensing education training shall receive initial and continuing approval without submission by the sponsoring organization.

(h) **Presumptive continuing education credit approval.**

(1) **Requirements.** A professional association may receive presumptive approval of the association's continuing education courses by satisfying the following requirements:

(A) The association shall have a mission statement that includes a commitment to enhance the professional, educational, or ethical skills of its members;

(B) The association shall maintain and govern a code of member conduct;

(C) The association shall offer educational programs relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma; and

(D) The association shall perpetuate its continuity through the election of officers.

(2) **Submissions.** Each professional association shall submit the following to be considered for initial and ongoing presumptive course approval:

(A) The association's mission statement;

(B) The association's code of member conduct;

(C) The chapter officers, the responsibilities for each officer, and the term of office for each officer;

(D) The mailing address and primary contact for the association; and

(E) The list of continuing education courses approved in Oklahoma and offered by the professional association in the past twenty-four (24) months.

(3) **Notification of approval or disapproval.**

(A) The Commissioner shall notify the association within ninety (90) days from the receipt of submission whether presumptive approval for continuing education courses was granted. The notification shall indicate the reasons for disapproval.

(B) Submissions to the Commissioner by an association seeking presumptive approval of continuing education courses shall include the course summary, instructor name, course date and location and shall be submitted to the Commissioner at least fifteen (15) business days prior to the presentation of the course.

(C) If the Commissioner receives a report or reports that the content of a continuing education course may violate paragraph 365:25-3-1(f)(7) of this section, the Commissioner may review the content and determine if the course should be disapproved for noncompliance. The Commissioner shall notify the association if the course has been disapproved due to non-compliance, and the association shall immediately cease offering the course upon receipt of the notification. The association may then make corrections to a disapproved course to bring the course into compliance with paragraph 365:25-3-1(f)(7) of this section and submit the course for approval by the Commissioner in the manner of an original submission for presumptive continuing education course approval.

(D) Should an association receive notification of three (3) disapproved courses within a twenty-four (24) month period, the association's presumptive approval for continuing education courses shall be rescinded for twenty-four (24) months after which time the association may re-apply for presumptive approval.

(4) **Assignment of course number.** The Commissioner shall assign a course number once the presumptive approval for continuing education courses has been granted and shall notify the association of the assigned course number. All future correspondence relating to that course shall reference the assigned course number.

(5) **Instructor approval.** Instructors shall be approved by the Commissioner at least fourteen (14) calendar days prior to a presentation of a course. The Commissioner may disapprove any course if instructor approval has not been granted.

(6) **Review.** Course approval shall be reviewed every three (3) years. The association shall re-submit the items required in subparagraph 365:25-3-14(H)(3)(B) of this section during the fourth quarter of the last approval year.

(7) **Agency management courses.** Agency management courses shall not be considered for presumptive continuing education approval.

(i) **Self study and distance learning courses.** The Insurance Commissioner shall determine appropriate guidelines and standards for self-study and distance learning CEC offerings. The guidelines and standards shall include authentication of the registered licensee, technology requirements for course delivery and testing protocols. Guidelines and standards shall be reviewed and updated as appropriate and published on the Commissioner's website annually. Failure to follow the guidelines and standards established by the Commissioner may result in denial of continuing education credit for the adjuster and revocation of the course approval and or provider status for the Provider.

(j) **Repeating courses.** An insurance adjuster may repeat a course within the twenty-four month period if the maximum credits designated for the course were not attained in the first attempt. By repeating the course, the adjuster may not during the twelve month period earn more than the maximum credits designated for the course. An adjuster may repeat a course after two (2) license renewal dates have elapsed and receive the maximum credits designated for the course.

(k) **Extension of time.** For good cause shown, the Commissioner may grant an extension of time during which the requirements imposed by the act may be completed. The extension shall not exceed twelve (12) months. The extension will not alter the requirements or due date of the succeeding twelve-month period. "Good cause" includes disability, natural disaster, or other extenuating circumstances. Each request for extension of time shall be in writing from the licensee and shall include details and any documentation to support the request. Each request must be received by the Commissioner no less than thirty (30) days before the expiration of the twenty-four month period.

(l) **Continuing education advisory committee.**

(1) There shall hereby be established the Continuing Education Advisory Committee. This committee shall consist of representatives from the Agents Licensing Division, and representatives from the industry (not to exceed three (3) individuals) as designated by the Commissioner. Members of the Advisory Board established by 36 O.S. § 6221 may also serve on the Continuing Education Advisory Committee. The committee shall meet at least quarterly and additionally as required. Members of the committee shall serve without pay and shall not be reimbursed for any expenses associated therewith.

(2) Prior to the Commissioner's approval or disapproval of a course in subsection 365:25-3-14(e), the Continuing Education Advisory Committee will review the course submitted and make its nonbinding recommendation to the Commissioner on granting or denying approval based upon information submitted pursuant to subsection 365:25-3-14(e) and additional information regarding the course, if necessary. Each course approval shall be valid for a period of no longer than two (2) years, unless the course has a material change. Material changes to courses require course resubmission for overall course review and approval. Course materials may be resubmitted as requested for review at the time of expiration. All existing courses previously approved and current with the Commissioner shall be submitted in accordance with the expiration date as granted by the Commissioner unless the course has a material change, as previously detailed.

(m) **Severability provision.** If any provision of this section, or application of such provision to any person or circumstances, shall be held invalid, the remainder of the section, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

365:25-3-15. Variable annuity licensing

~~No test shall be required of an~~ An applicant for a variable annuity license ~~if~~ shall:

(1) ~~The applicant provides~~ Provide proof of current ~~NASD~~ FINRA registration with series 6 or 7 and series 63 or 66, and

(2) ~~The applicant pays~~ Pay an additional license fee as required by 36 O.S. § 1435.23(A)(4)(b) with the submission of an application ~~and company endorsements~~ as prescribed by the Insurance Commissioner.

365:25-3-16. Examination exemptions

(a) The following applicants are cognizant of and capable of fulfilling the responsibilities of the license without an examination:

(1) limited lines producers,

(2) surplus lines brokers,

(3) aircraft title producer license if the applicant was licensed as a title insurance producer prior to November 1, 2006~~.~~, and

(4) a person licensed as an insurance producer in another state who moves to this state and makes application to become a resident licensee within ninety (90) days of establishing legal residence. The examination exemption shall apply for the lines of authority held in the prior state. A person shall qualify for this exemption by providing a clearance letter from the prior state dated within ninety (90) days from the date of receipt of the application.

(b) Multi-peril crop adjusters certified by the Federal Risk Management Agency working in partner with, or on behalf of, the Federal Crop Insurance Corporation may obtain a crop/hail license upon presentation of the federal certification without having to take an examination.

365:25-3-21. Training and education requirements for the sale of annuities

(a) Training and education requirements for producers who sell, solicit or negotiate annuities.

(1) An insurance producer shall not sell, solicit or negotiate the sale of an annuity product in this state unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided, product-specific training standards and materials to comply with this subsection.

(2) An insurance producer who engages in the sale, solicitation or negotiation of annuity products shall be licensed as a producer with a Life line of Authority and complete a one-time, four (4) hour credit training course as set forth in subsection (b). The course shall be approved by the Insurance Department and provided by an Insurance Department-approved education provider. The continuing education as required by this paragraph shall be applied as a continuing education course under Section 1435.29 of Title 36 of the Oklahoma Statutes.

(3) Insurance producers who currently hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the training requirements of this subsection within twelve (12) months after July 14, 2010.

(4) Individuals who obtain a life insurance line of authority on or after the July 14, 2010 may not engage in the sale, solicitation or negotiation of annuities until the annuity training course required under subsection (a)(2) has been completed.

(b) Training education requirements.

(1) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credit hours, but may be longer.

(2) The training required under this subsection shall include information on the following topics and any other topics approved and specified by the Insurance Commissioner:

(A) the types of annuities and various classifications of annuities,

(B) identification of the parties to an annuity,

(C) how fixed, variable and indexed annuity contract provisions affect consumers,

(D) the application of income taxation of qualified and non-qualified annuities,

(E) the primary uses of annuities, and

(F) appropriate sales practices, replacement and disclosure requirements.

(3) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

(4) Annuity training courses may be conducted and completed by classroom or self-study methods.

(c) Insurer requirements. An insurer shall verify that an insurance producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by Commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

(d) Training received in other states. The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this state.

SUBCHAPTER 5. BAIL BONDSMEN

PART 5. GENERAL PROVISIONS PERTAINING TO BAIL BONDSMEN

365:25-5-39. Affidavit as to undertaking

An Affidavit ~~As To~~ as to Undertaking ~~must~~ shall be included on every appearance bond and ~~should~~ shall declare the amount of premium (consideration) and security (collateral) received or promised. It ~~should~~ shall further include the nature and description of, and the name of the person from whom it was received or promised. Information provided on the Affidavit ~~As To~~ as to Undertaking ~~should~~ shall correspond with the information contained in the following:

(1) appearance bond,

(2) bondsman's office records, and

(3) monthly report.

365:25-5-40. Computation of time in 59 O.S.§1332

(a) In computing any period of time in 59 O.S. §1332, 12 O.S. §2006(A) will be followed. 12 O.S. §2006(A) states, in pertinent part, as follows: *The day of the act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a legal holiday as defined by Section 82.1 of Title 25 of the Oklahoma Statutes or any other day when the office of the court clerk does not remain open for public business until the regularly scheduled closing time, in which event the period runs until the end of the next day which is not a legal holiday or a day when the office of the court clerk does not remain open for public business until the regularly scheduled closing time. Unless otherwise provided by law, when the period of time prescribed or allowed is less than eleven (11) days, intermediate legal holidays and any other day when the office of the court clerk does not remain open for public business until the regularly scheduled closing time shall be excluded from the computation.*

(b) The defendant shall be returned to custody within ninety days or the forfeiture shall be paid on the ninety-first day, and the time begins to run as follows:

(1) If the bondsman dates the return receipt, or the date of receipt of the order and judgment of forfeiture is evidenced electronically, then the days start running the next day.

(2) If the bondsman ~~doesn't~~ does not date the return receipt or the date of receipt of the order and judgment of forfeiture is not evidenced electronically, but the insurer or professional does, or the date of receipt is evidenced electronically, then the days start running the next day.

(3) If neither the bondsman nor the insurer or professional dates the return receipt, nor is the date of receipt of the order of judgment of forfeiture evidenced electronically, then the days start running the day after the order and judgment of forfeiture was mailed.

365:25-5-44. Notice of return to custody

Following a forfeiture, if the defendant has been returned to custody as defined in 59 O.S. § 1332(C)(3), the bondsman shall file notice with the court clerk of the county where the forfeiture occurred by the ninety-first day after receipt of the order and judgment of forfeiture, certifying the defendant was returned to custody by the ninetieth day after receipt of the order and judgment of forfeiture. Failure to provide notice prior to the ninety-first day shall be a violation of 59 O.S. § 1310(A)(2).

PART 7. SPECIFIC FINANCIAL CIRCUMSTNACES WARRANTING RELEASE OF PROFESSIONAL DEPOSIT

365:25-5-50. Authority and scope

This regulation is promulgated by the Insurance Commissioner pursuant to Section 1306(A)(5) of Title 59 of the laws of this state to describe the nature and scope of the specific financial circumstances warranting a release of a bail bondsman's professional deposit.

365:25-5-51. Specific financial circumstances enumerated

(a) For purposes of Section 1306(A)(5) of Title 59 of the laws of this state, the specific financial circumstances warranting release of a professional deposit are:

(1) Fire that damages or destroys either the office or residence of the bondsman;

(2) Flood that damages or destroys either the office or residence of the bondsman;

(3) Other natural disaster that damages or destroys either office or residence of the bondsman;

(4) Medical problem or illness sustained by either the bondsman or a member of the immediate family of the bondsman.

(5) The bondsman has unused bail writing capacity of at least forty percent (40%) of their liability limit, and has at least twelve (12) consecutive months of being at sixty percent (60%) or below this writing limit.

(b) The bondsman shall have the burden of showing the Commissioner by clear and convincing evidence the existence or occurrence of the circumstances, as well as providing to the Commissioner any necessary supporting documentation or other evidence the Commissioner requires.

365:25-5-52. Time governing release of professional deposit

The Commissioner shall release the professional deposit no earlier than ninety (90) days following the receipt of the request for release.

365:25-5-53. Limitations upon release of professional deposit below applicable limits

The Commissioner shall not release any portion of the professional bondsman deposit that results in the deposit dropping below the applicable limit set by Section 1306(A)(2) of Title 59 of the laws of this state.

365:25-5-54. Review of bail bondsmen's administrative history before release of professional deposit

The Commissioner shall review the bondsman's administrative history to determine if the bondsman owes any outstanding fines to the Commissioner or has any pending or concluded disciplinary action for unpaid bail bond forfeitures. The Commissioner shall not release the deposit if outstanding fines are owed or if forfeitures were unpaid in the time allowed by Section 1332 of Title 59 of the laws of this state. The Commissioner also shall not release the deposit if there are more than three (3) final Insurance Department administrative actions in the twelve (12) months preceding the release request.

365:25-5-55. Denial of request if bail bondsman has prior forfeitures

The Commissioner shall refuse the bondsman's deposit release request if the Commissioner was ever ordered by a Hearing Examiner to pay any forfeiture from the bondsman's professional deposit.

365:25-5-56. Limits on outstanding liabilities

The outstanding liabilities of the bondsman cannot exceed sixty percent (60%) of the professional deposit writing limit for at least one year prior to making application for partial release of deposit.

365:25-5-57. Commissioner discretion to release amount less than requested

The Commissioner shall have the authority to release an amount less than requested by the professional bondsman, if the bondsman's requested amount will cause the remaining deposit to be insufficient to cover additional bail liabilities incurred by the bondsman.

365:25-5-58. Approval of final order by Commissioner

The final deposit release order shall be approved by the Commissioner or the Commissioner's designee, pursuant to Section 1306(A) (6) of Title 59 of the laws of this state.

SUBCHAPTER 9. PREPAID FUNERAL BENEFITS

365:25-9-3. Forms

(a) **General requirements.**

(1) **Application for prepaid funeral benefits permit form.** An ~~Application for Prepaid Funeral Benefits Permit, Form PFB-1,~~ application for Prepaid Funeral Benefits form shall be filed using the Prepaid Funeral Benefits Permit Original Application as set forth in Appendix C of this chapter. The application must be filed with and approved by the Insurance Commissioner before any contracts covered by this act may be marketed. The statutory fee of $50.00 must accompany this application. An NAIC UCAA Biographical Affidavit must be submitted for each owner(s) of the organization and each designated agent as defined by Section 6126 of the Act.

(2) **Bond form requirements.** Appendix D of this chapter is a sample bond to be used in connection with "The Act". Any variance from this form must have the prior written approval of the Insurance Commissioner. If any bond required by "The Act" is canceled for any reason, a thirty (30) day written notice must be given by the insurer to the Insurance Commissioner.

(3) **Conversion Forms.** Applications for Conversion from a trust funded prepaid funeral benefit to an insurance-funded prepaid funeral benefit shall be filed with and approved by the Insurance Commissioner before any contracts covered by "The Act" may be converted. Applications for Conversion shall be filed using the Application for Conversion form as set forth in Appendix R of this chapter. Any variance from this form must have prior written approval by the Insurance Commissioner.

(4) **Notice of Sale.** The seller of a prepaid funeral benefits permit holding funeral home must make application forty-five (45) days prior to the transfer of ownership using the Sellers Notice to the Insurance Commissioner (PFSN 2009) form as set forth in Appendix X of this chapter. In addition to the notice, the seller must also submit a listing of unrealized prepaid funeral contracts. Insurance funded contracts should be listed independently from trust funded contracts. The listing will, at minimum, reflect the contract holder's name, contract number, contract value, the name of the insurer and the policy's face value (when applicable), and the trust value at the time of notice (when applicable).

(5) **Assumption Affidavit.** The buyer of a prepaid funeral benefits permit holding funeral home must notify the Commissioner of their intent to purchase thirty (30) days prior to transfer of ownership using the Assumption Affidavit (PFAA 2009) form as set forth in Appendix Y of this chapter.

(6) **Application for Renewal.** The application for renewal of a prepaid funeral benefits permit must be filed with the Commissioner no later than December 31 of each year, using the Application for Renewal (PFBR 2009) form as set forth in Appendix M of this chapter, in order to renew the permit for the succeeding calendar year. The statutory fee of $50.00 must accompany the application.

(b) **Additional general requirements.** ~~Withdrawal forms, individual refunds, renewal applications, and the annual statement of financial condition shall be submitted to the Insurance Commissioner for review by submitting one copy of the withdrawal form and individual refund. Submit the original renewal application and annual statement of financial condition.~~

(1) ~~**Withdrawal forms.** Appendix E of this chapter is the application which must be submitted to the Insurance Commissioner in order to withdraw funds after a contract has been fulfilled.~~

~~(2) **Individual refunds.** Appendix F of this chapter, must be submitted to the Insurance Commissioner when a person desires to withdraw any funds deposited for prepaid funeral expenses prior to fulfillment of the contract.~~

~~(3)~~ **Annual reports.**

(A) Annual reports must be filed in accordance with Section 6128 of "The Act". Such reports should be submitted in columnar form in alphabetical order according to the last name of the contract holder. ~~Appendix G of this chapter is included for the sole purpose of establishing guidelines for this report.~~ A complete annual report shall be composed of the following items arranged in the order shown below:

(i) PF-1-a
(ii) PF-1-b
(iii) PF-1-c
(iv) PF-1-d
(v) PF-2-a
(vi) PF-2-b
(vii) PF-2-c
(viii) PF-3

(B) Computer print-outs may be submitted in lieu of the reports listed above so long as each legibly provides no less information than shown in the Insurance Commissioner's sample forms. Not less than one page of each annual report form shown above, other than the PF-2-b, shall be submitted. However, where a particular form is not relevant to the operations of a given permitholder, it may be submitted clearly marked, "Not Applicable".

~~(C) All itemized statements of charges must be submitted with the annual report in accordance with Section 6123 of Title 36 of the Oklahoma statutes.~~

(~~4~~2) **Annual statement of financial condition.** An Annual Statement of Financial Condition ~~(~~Reconciliation of Trust Accounts~~)~~(form PF-3) must be filed in accordance with Section 6129 of "The Act". ~~Appendix H of this chapter (Form PF-3) is included for the sole purpose of establishing guidelines for this statement.~~

~~(5) **Renewal application.** A renewal application (PFB-2) must be filed with the Commissioner no later than December 31 of each year in order to renew the permit for the succeeding calendar year. The statutory fee must accompany this renewal application.~~

APPENDIX C. PREPAID FUNERAL BENEFITS PERMIT ORIGINAL APPLICATION [NEW]

General Information

Name of Organization:
_____
include True name and if applicable Doing Business As name)

Type of Organization: _____ Sole Proprietor* _____ Partnership* _____ Corporation*

State Tax ID: _____ Federal Tax ID: _____

*Each Proprietor or member of the Partnership/Corporation must submit a Biographical Affidavit

Physical Address:
_____

Mailing Address:
_____

Phone Number: _____ Alt Phone Number:_____
Fax Number:_____
(if applicable)

Email Address: _____ Web Address: _____

Funeral Director in Charge:
_____

General Interrogatories

1. Has the owner or any principal employees of the organization been admonished, censored, suspended or fined within the last year by the Oklahoma Funeral Board for violations involving funeral home activities?
Yes _____ No _____
If yes, please attach statement of explanation.

2. Have any of the principals (owner[s], manager, employees with fiduciary duties, etc.) ever been convicted of a felony or misdemeanor involving moral turpitude?
Yes_____ No _____
If yes, explain:
_____

3. Have you or your organization ever applied for a permit from this Department?
Yes_____ No _____
Were you approved or denied?
Approved_____ Denied _____
If denied, please attach statement of explanation.
If approved, did your permit lapse, was it sold or other
_____?
Please attach statement of explanation.

Prepaid Funeral Contract Funding

Insurance Assignment Only

Does the establishment offer an in-house insurance agent? _____ If yes, please provide agent's Name and License Number_____

Insurance and/or Trust

Financial Institution where trust monies will be deposited; attach additional sheet if necessary.

_____

Name Address City Zip

(A Trust Agreement must be submitted for each financial institution listed.)

Designated Agent(s), as defined in §6126, who will be responsible for the deposit of funds collected under contracts for prepaid funeral benefits; attach additional sheet if necessary.

_____

Name Address City Zip

_____

Name Address City Zip

(Submit a Biographical Affidavit for each Designated Agent.)

I, _____, being first duly sworn, state that I have read the within and foregoing application and that the answers supplied by me therein are true and correct to the best of my knowledge and belief and further that I will comply with the Prepaid Funeral Benefit laws of Oklahoma and the Rules of the State Insurance Commissioner in all my conduct under the permit.

STATE OF _____)
) ss.
COUNTY OF _____)

_____ _____
Signature of Applicant Date

_____
Applicant's Printed Name and Title

_____ _____
Notary Public My Commission Expires

(notary seal)

The statutory fee of $50.00, made payable to the Oklahoma Insurance Department, must accompany this application.

PFB-2009

APPENDIX M. APPPLICATION FOR RENEWAL OF PREPAID FUNERAL BENEFITS PERMIT [NEW]

Application for Renewal of Prepaid Funeral Benefits Permit - Renewal

Year _____

Permit Number: _____

Name of Organization: _____
(include True name and if applicable Doing Business As name)
hereby makes application for a renewal of permit from the Oklahoma Insurance Commissioner as authorized by Title 36 § 6121 et seq.
Physical Address: _____

Mailing Address: _____

Phone Number: _____ Alt Phone Number: _____ Fax Number: _____

Email Address: _____ Web Address:_____

Funeral Director in Charge:_____

The organization also agrees to comply with all requirements of the Prepaid Funeral Benefits Act (§ 6121 et seq.) which in part includes notification of those acting as designated agents (§6126). Please create a listing of the organizations designated agents and attach the listing to this application for renewal.

Does the establishment offer an in-house insurance agent? _____ If yes, please provide:
Agent's Name and License Number:_____

I, _____, being first duly sworn, state that I have read the within and foregoing application for renewal and that the answers supplied by me therein are true and correct to the best of my knowledge and belief and further that I will comply with the Prepaid Funeral Benefit laws of Oklahoma and the Rules of the State Insurance Commissioner in all my conduct under the permit.

STATE OF _____)
) ss.
COUNTY OF _____)

_____ _____
Signature of Applicant Date

_____
Applicant's Printed Name and Title

_____ _____
Notary Public My Commission Expires (notary seal)

***A Fifty Dollar ($50.00) renewal fee, payable to the Oklahoma Insurance Department, must accompany application.**
PFBR-2009

APPENDIX X. SELLERS NOTICE TO THE INSURANCE COMMISSIONER [NEW]

Sellers Notice to the Insurance Commissioner

_____
Permit Number

KNOW ALL BY THESE PRESENTS that I, _____, (Seller) current
(Current Owner)
owner of _____ doing business as a Prepaid Funeral Benefits
(Name of Funeral Establishment)

organization in the State of Oklahoma and required by OKLA. STAT. TIT. 36 § 6124.1 to provide notice of Transfer in Ownership hereby submit to you the following;

a) Name of Acquiring Organization _____

b) Date Acquiring Organization Assumes Control _____

c) Attached and made part of this Notice is the required listing of outstanding Prepaid Funeral Contracts

The Seller, now obligates the acquiring organization to apply for and receive a permit of sameness from the Insurance Commissioner of the State of Oklahoma, prior to acting as the Prepaid Funeral Benefits organization for all prepaid funeral contracts included in the transfer of ownership.

Seller further agrees that all monies paid into Trust as part of the prepaid funeral contract remain under the control of Seller until the Insurance Commissioner, in order to safeguard the rights and interests of the individual prepaid funeral contract holder, expressly authorizes the transfer of said Trust monies to the Buyer.

I, _____hereby affirm that all information provided in this notice
(Current Owner)
and inscribed on the attached listing of outstanding Prepaid Funeral Contracts is true and correct. I further affirm that I have disclosed any adverse change foreseen due to the transfer in Ownership.

State of _____

County of _____

Signed and affirmed before me on _____ by_____
(Date) *(Current Owner)*

_____
(Signature of Notarial Officer)

(seal)

_____
(Title)

_____
(Commission Expiration)

PFSN 2009

APPENDIX Y. ASSUMPTION AFFIDAVIT [NEW]

Assumption Affidavit

KNOW ALL BY THESE PRESENTS that I,_____, (Acquirer), acting
Acquirer of Funeral Establishment)

in accordance with OKLA. STAT. TIT. 36 §6124.1, now make notice of intent to purchase _____,a provider of prepaid funeral services and/or merchandise.
(Name of Funeral Establishment)

Application has been made to the Insurance Commissioner of the State of Oklahoma to enter into contracts and receive payments thereon for prepaid funeral services and/or merchandise, in accordance with OKLA. STAT. TIT. 36 §6121 et seq.

As the Acquirer , I have been made aware of existing insurance funded and trust funded contracts for prepaid funeral services and/or merchandise underwritten by the Seller and accept the Sellers identification and itemization of said contracts.

Acquirer further agrees that all monies accrued in the Seller's Trust remain under the Sellers control until the Insurance Commissioner, as means of safeguarding the rights and interests of the individual prepaid funeral contract holder, expressly authorizes transfer of said Trust monies to the Acquirer.

I, _____ hereby affirm that all information provided in this
(Acquirer of Funeral Establishment)
affidavit is true and correct. I further affirm that I have disclosed any adverse change foreseen due to the transfer in Ownership.

State of _____

County of _____

Signed and affirmed before me on _____ by_____
(Date) *(Buyer)*

_____
(Signature of Notarial Officer)

(seal) _____
(Title)

_____
(Commission Expiration)

PFAA 2009

[OAR Docket #10-756; filed 5-4-10]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 40. HEALTH MAINTENANCE ORGANIZATIONS (HMO)

[OAR Docket #10-757]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 3. Financial
Part 3. Holding Company System
365:40-3-14. Prior approval pursuant to 36 O.S. § 6903(C) [AMENDED]
Subchapter 5. Life, Accident & Health Division and Consumer Assistance and Claims Division Rules
Part 1. General Provisions
365:40-5-2. Form filings [NEW]
AUTHORITY:
Insurance Commissioner, 36 O.S. §§ 307.1 and 6903(D)
DATES:
Comment period:
January 16, 2010 through February 16, 2010
Public hearing:
February 25, 2010
Adoption:
March 5, 2010
Submitted to Governor:
March 8, 2010
Submitted to House of Representatives:
March 8, 2010
Submitted to Senate:
March 8, 2010
Gubernatorial approval:
March 25, 2010
Legislative approval:
Failure of the Legislature to disapprove the rules resulted in approval on May 4, 2010
Final adoption:
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Effective:
July 14, 2010
SUPERSEDED EMERGENCY ACTIONS:
n/a
INCORPORATIONS BY REFERENCE:
n/a
ANALYSIS:
The amendment to Section 365:40-3-14 requires submission of items required pursuant to 36 O.S. § 6903(C)(5) and (6) to the Rate and Form Compliance Division of the Oklahoma Insurance Department and requires an Amended Registration Statement (HMO Form B) to be filed for all items approved by the Insurance Commissioner. The amendment also provides that approvals granted under other administrative rules of the Insurance Department will not be superseded nor transactions occurring prior to July 14, 2010.

A new Section 365:40-5-2 requires all group and individual contract forms and evidence of coverage or amendments thereto to be filed electronically for approval before use pursuant to 36 O.S. §§ 6903(C)(5) and (6) and 6908(E),(F) and (G). An appropriate fee shall accompany the filings, which must be filed with the Rate and Form Compliance Division of the Oklahoma Insurance Department.
CONTACT PERSON:
Melanie Pouncey Sullivan, Assistant General Counsel, Oklahoma Insurance Department, 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112, (405) 521-2749

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 14, 2010:

SUBCHAPTER 3. FINANCIAL

PART 3. HOLDING COMPANY SYSTEM

365:40-3-14. Prior approval pursuant to 36 O.S.§ 6903(C)

(a) Pursuant to 36 O.S. § 6903(D), the prior written approval of the Insurance Commissioner shall be required for amendments or modifications to items required by 36 O.S. § 6903(C)(4), (5), (6), and (11).

(b) Requests for prior written approval required by 36 O.S. § 6903(C)(4) and (11) shall be made on HMO Form D as set forth in Appendix D of this Chapter. Pursuant to O.A.C. 365:40-3-12, an Amended Registration Statement (HMO Form B) shall be filed for all items approved by the Insurance Commissioner.

(c) Requests for prior written approval of items required by 36 O.S. § 6903(C)(5) and (6) shall be submitted to the Rate and Form Compliance Division of the Oklahoma Insurance Department. Pursuant to Section 365:40-3-12, an Amended Registration Statement (HMO Form B) shall be filed for all items approved by the Insurance Commissioner.

(d) Nothing in this section shall supersede approvals granted under other sections of this title or transactions occurring prior to July 14, 2010.

SUBCHAPTER 5. LIFE, ACCIDENT & HEALTH DIVISION AND CONSUMER ASSISTANCE AND CLAIMS DIVISION RULES

PART 1. GENERAL PROVISIONS

365:40-5-2. Form filings

All group and individual contract forms, evidence of coverage or amendments thereto, shall be filed for approval before use pursuant to 36 O.S. §§ 6903(C)(5) and (6) and 6908(E),(F) and (G). The appropriate filing fee, as provided in 36 O.S. § 321, shall accompany each filing. All filings submitted pursuant to this section shall be submitted electronically to the Rate and Form Compliance Division of the Oklahoma Insurance Department.

[OAR Docket #10-757; filed 5-4-10]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 45. HEALTH CARE FOR OKLAHOMANS REGULATION

[OAR Docket #10-758]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 1. Plan Requirements [NEW]
365: 45-1-1. Standard health benefit plan requirements [NEW]

365:45-1-2. Standard health benefit plan disclosure requirements [NEW]
Subchapter 3. Product Certification Requirements [NEW]
365:45-3-1. Certification of insurance programs for recommendation by the Health Care for the Uninsured Board [NEW]
Subchapter 5. Producer Education Requirements [NEW]
365:45-5-1. Training and education requirements for producers to market Health Care for the Uninsured Board (HUB) certified products [NEW]

AUTHORITY:
Insurance Commissioner, 36 O.S. §§307.1, and 4601 through 4603.

DATES:
Comment period:
January 16, 2010 through February 16, 2010
Public hearing:
February 25, 2010
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March 5, 2010
Submitted to Governor:
March 8, 2010
Submitted to House of Representatives:
March 8, 2010
Submitted to Senate:
March 8, 2010
Gubernatorial approval:
March 25, 2010
Legislative approval:
Failure of the Legislature to disapprove the rules resulted in approval on May 4, 2010
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Effective:
July 14, 2010

SUPERSEDED EMERGENCY ACTIONS:
Superseded rules:
Subchapter 1. Plan Requirements [NEW]
365: 45-1-1. Standard health benefit plan requirements [NEW]
365:45-1-2. Standard health benefit plan disclosure requirements [NEW]
Subchapter 3. Product Certification Requirements [NEW]
365:45-3-1. Certification of insurance programs for recommendation by the Health Care for the Uninsured Board [NEW]
Subchapter 5. Producer Education Requirements [NEW]
365:45-5-1. Training and education requirements for producers to market Health Care for the Uninsured Board (HUB) certified products [NEW]

Gubernatorial approval:
October 2, 2009
Register publication
27 Ok Reg 177
Docket number:
09-1291

INCORPORATIONS BY REFERENCE:
n/a

ANALYSIS:
House Bill 2026 directs the Insurance Commissioner in collaboration with the Oklahoma Health Care Authority to initiate a program to encourage enrollment of individuals not covered by insurance or Medicaid in health insurance programs. This program includes the creation of a Health Care for the Uninsured Board ("HUB"). The laws enacted in House Bill 2026 direct the affected agencies to establish a system of certification for insurance programs offered to be recommended by the HUB and to provide training and education requirements for producers to market HUB-certified products.

CONTACT PERSON:
Melanie Pouncey Sullivan, Assistant General Counsel, Oklahoma Insurance Department, 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112, (405) 521-2749

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 14, 2010:

SUBCHAPTER 1. PLAN REQUIREMENTS

365:45-1-1. Standard health benefit plan requirements

The standard health benefit plan defined in Section 4415 of Title 36 of the Oklahoma Statutes shall:

(1) Comply with the general rules for individual accident and sickness policies specified in OAC 365:10-5-5(b), 'General Rules';

(2) Provide benefits at least equivalent to the category of coverage specified in OAC 365:10-5-5(f), 'Major Medical Expense Coverage'; and

(3) Be guaranteed renewable.

365:45-1-2. Standard health benefit plan disclosure requirements

A standard health benefit plan shall contain the following disclosures:

(1) The disclosure required by Section 4415(B)(2) of Title 36 of Oklahoma Statutes shall be located on the first page of the policy or included on a notice affixed to the first page of the policy.

(A) The disclosure shall be printed in bold type in a font size at least two (2) points larger than the other text of the policy.

(B) The disclosure shall recite the statutory language verbatim.

(2) At the time of application, but not later than policy delivery, an insurer providing a standard health benefit plan shall provide the applicant or policyholder with a written disclosure statement that includes the information required by Section 4415(C) of Title 36 of the Oklahoma Statutes.

(A) An insurer shall retain a signed copy of the disclosure statement referenced in this subsection.

(B) Upon renewal of a standard health benefit plan, an insurer shall provide the disclosure statement referenced in this subsection and shall request the insured to return a signed copy to the insurer.

(C) Upon request, an insurer shall provide to the Insurance Commissioner a copy of the signed disclosure statement or evidence that the statement was provided to the insured and that the insured was requested to return a signed copy to the insurer.

SUBCHAPTER 3. PRODUCT CERTIFICATION REQUIREMENTS

365:45-3-1. Certification of insurance programs for recommendation by the Health Care for the Uninsured Board

In order to facilitate the certification of insurance programs by the Insurance Commissioner to be recommended by the Health Care for the Uninsured Board (HUB), any insurer desiring to have an insurance program certified shall submit

information upon forms provided by the Insurance Commissioner.

(1) Both individual and group products may be certified.

(2) Insurance provided pursuant the Health Insurance High Risk Pool Act, Sections 6531 through 6545 of Title 36 of the Oklahoma Statutes, is deemed certified for recommendation by the HUB.

(3) Insurance for which an individual has qualified for a subsidy under the premium assistance program pursuant to the Oklahoma Medicaid Program Reform Act of 2003, Sections 1010.1 through 1010.13 of Title 56 of the Oklahoma Statutes, is deemed certified for recommendation by the HUB.

SUBCHAPTER 5. PRODUCER EDUCATION REQUIREMENTS

365:45-5-1. Training and education requirements for producers to market Health Care for the Uninsured Board (HUB) certified products

(a) Initial and renewal credentialing requirements.

(1) A producer licensed for the accident and health line of insurance may become credentialed to market HUB certified plans in accordance with Section 4602(C)(2) of Title 36 of the Oklahoma Statues.

(2) In order to maintain credentials for the HUB program, all producers credentialed to market HUB certified health plans shall satisfactorily complete four (4) hours of HUB designated continuing education prior to each biennial license renewal period. Failure to complete the required continuing education shall result in the termination of the HUB credential of the producer.

(b) Application, qualifying examination, hours of training required.

(1) Insurance producers who hold an active producer license for the accident and health line of insurance may apply for HUB credentialing by completing and submitting an application specified by the Insurance Commissioner.

(2) Insurance producers shall take a credentialing qualifying examination which will determine the number of education hours to be taken by the producer in the credentialing process.

(3) Qualifying examinations shall be provided at locations and times designated by the Insurance Commissioner.

(4) The qualifying examination shall consist of subject matter specified by the Insurance Commissioner. The examination shall be closed book meaning no computer or electronic equipment shall be used by an applicant during the exam for the purposes of seeking information to answer examination questions. Information regarding the subject matter of the exam shall be made available on the official web site of the Insurance Department.

(5) Any producer who scores below 85 percent (85%) on the credentialing qualifying examination shall take fourteen (14) hours of approved HUB credentialing education consisting of six (6) hours of basic credentialing education, and upon completion, take eight (8) hours of advanced credentialing education. Producers who score 85 percent (85%) or above on the qualifying examination shall be required to complete eight (8) hours of advanced credentialing education.

(6) The six (6) hours of basic credentialing education required by paragraph 5 of this subsection shall be taken in a single, six (6) hour course. The hours may be taken through the internet or in a classroom environment. Credentialing education taken by correspondence course shall not qualify for basic credentialing education credit.

(7) The eight (8) hours of advanced credentialing education required by paragraph 5 of this subsection shall be taken in a single eight (8) hour course and shall only be available in a classroom environment. Advanced credentialing education taken through the internet or by correspondence classes shall not qualify for advanced credentialing education credit.

(8) Outlines for the basic and advanced education courses shall be specified by the Insurance Commissioner.

(9) Credentialing education courses shall be subject to the continuing education course approval requirements specified in OAC 365:25-3-1(f).

(10) All education hours taken for the purpose of becoming credentialed to market HUB certified plans shall count toward the continuing education requirement set out in Section 1435.29 of Title 36 of the Oklahoma Statutes and OAC 365:10:25-3-1.

(11) All continuing education hours required by paragraph (2) of this subsection shall be completed online or through classroom environments. Correspondence courses shall not be accepted.

(c) Education provider examination administration requirements. Individuals, providers and entities approved by the Insurance Commissioner to administer the qualifying examination shall attest that the examination was proctored and provided in a secure environment, which means that no computer or electronic equipment shall be used by an applicant during the exam for the purposes of seeking information to answer examination questions. Classroom study materials may not be used to complete the examination. Individuals, providers and entities administering the qualifying examination shall keep a copy of the attestation for five (5) years. The attestation shall be made available to the Insurance Commissioner upon request.

[OAR Docket #10-758; filed 5-4-10]

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

[OAR Docket #10-801]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 3. Affirmative Action and Equal Employment Opportunity
Part 3. Affirmative Action
530:10-3-33.4 [AMENDED]
530:10-3-33.5 [AMENDED]
530:10-3-33.6 [AMENDED]
530:10-3-33.7 [AMENDED]
530:10-3-33.8 [AMENDED]
530:10-3-33.9 [AMENDED]
530:10-3-33.11 [AMENDED]
Subchapter 7. Salary and Payroll
Part 1. Salary and Rate of Pay
530:10-7-12
Subchapter 9. Recruitment and Selection
Part 3. Written and Performance Tests
530:10-9-37 [AMENDED]
530:10-9-38 [AMENDED]
Subchapter 13. Reduction-in-Force
Part 1. General Provisions for Reduction-in-Force
530:10-13-3 [AMENDED]
Subchapter 15. Time and Leave
Part 5. Miscellaneous Types of Leave
530:10-15-45 [AMENDED]
Subchapter 17. Performance Evaluation and Career Enhancement Programs
Part 7. Carl Albert Public Internship Program
530:10-17-70 [AMENDED]
530:10-17-75 [AMENDED]
530:10-17-76 [NEW]
530:10-17-77 [AMENDED]
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None.
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The proposed amendments to 530:10-3-33.4-33.9 and 530:10-3-33.11 are being proposed to clarify and make the rules uniform to current practices and procedures and to omit duplicative or obsolete language. The proposed amendments to 530:10-7-12 are to clarify payment of overtime compensation. The proposed amendments to 530:10-9-37 and 38 are to amend the rules to be consistent with the current testing procedures and processes. The proposed amendments to 530:10-13-3 are necessary due to the recent enactment of HB 1296, which provides that if the appointing authority is governed by an elected official, notice of a reduction-in-force does not have to be approved by the agency's cabinet secretary and to make this emergency rule permanent. The proposed amendments to 530:10-17-70,75,76 and 77 are necessary due to the recent enactment of SB 670, which created a new internship category (Senior Undergraduate Internship) and to make this emergency rule permanent. The proposed amendments to 530:10-15-45 are necessary to amend the Merit Rules to be consistent with recent federal amendments to the Family and Medical Leave Act and to make this emergency rule permanent.
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 11, 2010:

SUBCHAPTER 3. AFFIRMATIVE ACTION AND EQUAL EMPLOYMENT OPPORTUNITY

PART 3. AFFIRMATIVE ACTION

530:10-3-33.4. Present staffing report

All affirmative action plans shall include a report of the distribution of employees among the EEO job categories as of June **30** immediately before the beginning of the new affirmative action plan period. On ~~a~~ the Present Staffing form prescribed ~~or approved~~ by the Administrator, the Appointing Authority shall list the total number of full-time employees ~~listed by male, female, individual minority, and total minority~~ within each EEO job category.

530:10-3-33.5. Job group analysis

Affirmative action plans for agencies authorized **15** or more full-time-equivalent employees shall include an analysis of the racial or ethnic and sexual composition of the present workforce by job groups. Job groups shall be based on similar

work content, advancement opportunities, and rate of pay. Appointing Authorities shall:

(1) Use the EEO job categories as a basis for job group analysis; however an Appointing Authority may subdivide an EEO job category into several job groups;

(2) Assign all jobs to job categories using the EEO job category listing published by the Administrator unless the level of assigned responsibility for the job family within the agency matches the description for another category better than the category listed in the Administrator's publication;

(3) List the number of employees and the total number of male, female, total minority and individual employees in each job group; and

(4) Complete ~~a~~ the Job Group Analysis form prescribed ~~or approved~~ by the Administrator to record job group analysis data. ~~The form shall provide spaces for job group information, including but not limited to: EEO job category and job group, salary or pay band, job titles, numbers of employees by job title, group, and category.~~

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 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 the following availability factors when taking into account how individuals are usually selected for employment within each job group:

(A) Percentage of minorities or females having requisite skills in the reasonable recruitment area. The reasonable recruitment area is defined as the geographical area from which the agency usually seeks or reasonably could seek workers to fill the positions in question;

(B) Percentage of minorities or females promotable, transferable, and trainable within the agency's organization. Trainable refers to those employees within the agency who, with appropriate training that the Appointing Authority is reasonably able to provide, could become promotable or transferable during the plan year. Unless a greater weight is approved by the Administrator, the weight for this factor shall not exceed **15%**; and

(C) 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;

(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~~ the Availability Analysis 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 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 may use the "80% method" as described in paragraph (1) of this subsection, or 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~~ the Utilization Analysis and Annual Goals form prescribed ~~and 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.

530:10-3-33.8. Personnel transaction report

All affirmative action plans shall include a report of personnel transactions. The report shall be an agency-wide summary of personnel transactions showing the progress made toward achieving any affirmative action goals for the preceding year. An Appointing Authority shall:

(1) List the total number of employees and the total number of male, female, individual minority, and total minority employees present at the beginning of the preceding plan period and the corresponding numbers at the end of the period. If the numbers for the beginning of the period are inconsistent with the numbers submitted in the preceding plan, the Appointing Authority shall include an explanation for the differences;

(2) List the number of male, female, individual minority, and total minority employees affected by the following types of personnel transactions during the period;

(A) **New hires.** This type includes new full-time appointments, transfers in, reinstatements, and recalls, but does not include temporary, part-time, or time-limited appointments;

(B) **Promotions.** In addition to promotions, this type includes direct reclassifications resulting in a higher rate of pay, and any other transactions resulting in an employee being reclassified to a different state job with a higher pay band assignment or to a higher level within the same job family;

(C) **Demotions.** This group includes both voluntary and involuntary demotions, direct reclassifications to a job with a lower pay band, and any other transactions resulting in an employee being assigned to a lower pay band or to a lower level in the same job family;

(D) **Separations.** This group includes discharges, resignations, transfers out, retirements, reduction-in-force, or other voluntary or involuntary separation from full-time employment with the agency, but not including the separation of persons on temporary, part-time, or time-limited appointments;

(3) List summary information on ~~a~~ the Personnel Transactions Report form prescribed ~~or approved~~ by the Administrator~~, including but not limited to: staffing numbers at the beginning and end of the period, gains and losses during the period, personnel transaction goals for hiring and promotions goals for the preceding period, and the actual numbers of new hires, promotions, demotions, and separations. If the agency is authorized **15** or more full-time equivalent employees, the Appointing Authority shall include the hiring goals and any operational promotional goals for the preceding period on the form~~.

530:10-3-33.9. Evaluation of preceding years' AA and EEO efforts

(a) All affirmative action plans shall include a narrative evaluation of affirmative action and equal employment opportunity. The narrative shall include but not be limited to descriptions of:

(1) good faith efforts to achieve any goals and timetables established in the preceding plan;

(2) actions taken to correct any problem areas identified in the preceding year; and

(3) the status of recruitment, hiring, and promotion of females, males, and minorities within job categories.

(b) All affirmative action plans shall include a list of the number of new hires for the past 3 years on ~~a~~ the Evaluation of Previous EEO Efforts (NEW HIRES) form prescribed ~~or approved~~ by the Administrator. ~~The form shall provide spaces for staffing information, including but not limited to: total hires during each period and totals for the **3** year period with sub-totals for individual minorities, total minorities, males and females.~~

530:10-3-33.11. Goals and timetables

(a) Affirmative action plans for agencies authorized **15** or more full-time-equivalent employees shall include flexible goals and timetables for job groups in the agency's workforce that show underutilization. Agencies using the "80% method" are not required to establish hiring goals for females and each minority group that is underutilized within a job group. For each job group in which underutilization is found for minorities or females, an Appointing Authority shall consider affirmative action to increase the representation of the group that is underutilized. An Appointing Authority shall:

(1) List job groups that show underutilization ~~and the number of new hires projected~~ during the affirmative action plan period; and

~~(2) Set goals for job groups showing underutilization; and~~

(~~3~~2) Complete ~~a~~ the Utilization Analysis and Annual Goals form prescribed ~~and approved~~ by the Administrator ~~which shall include but not be limited to spaces for job groups, minorities and females, projected appointments, annual placement goals for new hires and promotions (optional) and for ultimate goals (optional)~~.

SUBCHAPTER 7. SALARY AND PAYROLL

PART 1. SALARY AND RATE OF PAY

530:10-7-12. Payment of Overtime

(a) An Appointing Authority shall neither require nor allow FLSA Non-Exempt 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) The Executive Branch of the State of Oklahoma is one employer for FLSA purposes; therefore, concurrent employment in more than one agency is considered joint employment. Employees working in one or more nonexempt positions in Executive Branch agencies and who work more than 40 total hours per week shall be eligible for overtime. Employees shall be required to notify their current agency upon accepting employment with another Executive Branch agency. It will be the responsibility of all agencies involved to insure that all FLSA requirements associated with multiple agency appointments are met.

(d) 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.

(e) 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.

(f) 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.

SUBCHAPTER 9. RECRUITMENT AND SELECTION

PART 3. WRITTEN AND PERFOMANCE TESTS

530:10-9-37. Repeating examinations

(a) A person may repeat a written test or performance test at intervals that shall be determined and made public by the Administrator.

(b) The repeat interval for a written or performance test shall apply to both entrance and promotional examinations. The most recent, valid score on a written test will be used. An applicant may request to be certified with a score on a performance test other than the most recent one, provided that the score requested on a test is consistent with guidelines issued and made public by the Administrator. 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 30 days ~~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 period of time designated by the Administrator consistent with guidelines issued and made public by the Administrator.

SUBCHAPTER 13. REDUCTION-IN-FORCE

PART 1. GENERAL PROVISIONS FOR REDUCTION-IN-FORCE

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 or if the appointing authority is governed by an elected official, 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(D) of Title 74 of the Oklahoma Statutes.

SUBCHAPTER 15. TIME AND LEAVE

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;

(4) a serious health condition that makes the employee unable to perform the functions of the employee's job; or

(5) any qualifying exigency (as defined by U.S. Department of Labor Regulations) arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty or has been notified of an impending call or

order to active duty in the Armed Forces in support of a contingency operation.

(c) An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember shall be entitled to a total of 26 weeks of leave during a 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period. During the single 12-month period described in this paragraph, an eligible employee shall be entitled to combined total of 26 weeks of leave under paragraph (b) and (c). Nothing in this paragraph shall be construed to limit the availability of leave under paragraph (b) during any other 12-month period.

(d) 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 the health care provider of the employee or the employee's ill family member. An Appointing Authority may require a certification issued by the health care provider of a covered servicemember being cared for by an employee.

(e) 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.

(f) When family and medical leave is taken to care for a sick family member as defined in (b)(3) of this Section, a covered servicemember as referenced in (c) 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. When family and medical leave is taken for a qualifying exigency as referenced in (b)(5) of this Section, leave may be taken intermittently or on a reduced leave schedule. 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.

(g) 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. In any case in which the necessity for leave under (b)(5) of this Section is foreseeable, the employee shall provide such notice to the employer as is reasonable and practicable. 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.

(h) 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.

(i) 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";

(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 FMLA entitlement [29 CFR 825.207(i)]~~; or

(5) Record as leave without pay in accordance with 530:10-15-47.

(j) The agency shall continue paying the employee's insurance coverage while the employee is on family and medical leave.

(k) 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.

(l) An employee shall not be required to take more leave than necessary to resolve the circumstance that precipitated the need for leave.

SUBCHAPTER 17. PERFORMANCE EVALUATION AND CAREER ENHANCEMENT PROGRAMS

PART 7. CARL ALBERT PUBLIC INTERNSHIP PROGRAM

530:10-17-70. Purpose

(a) The rules in this Part establish policies and procedures to implement the Carl Albert Public Internship Program in accordance with Sections 840-3.2 through 840-3.7 of Title 74 of the **Oklahoma Statutes.**

(b) The Carl Albert Public Internship Program consists of ~~Executive Fellows internships and undergraduate internships~~. Executive Fellows Internships, Undergraduate Internships and Senior Undergraduate Internships. *The purposes of the program shall be to assist students at institutions of higher education in gaining experience and knowledge in state government and to encourage recruitment of such students to pursue careers in state government service* [74:840-3.2]. The rules governing the program apply to both merit system and non-merit system employing agencies.

(c) This part contains ~~**3**~~ **4** groups of Sections:

(1) Section 530:10-17-74 pertains only to Undergraduate Internships,

(2) Sections 530:10-17-75 and 530:10-17-84 pertain only to Executive Fellows Internships, ~~and~~

(3) Section 530:10-17-76 pertains only to Senior Undergraduate Internships, and

(4) Sections 530:10-17-77 through 530:10-17-82 pertain generally to the Carl Albert Public Internship Program.

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(A)~~(2)~~(3)]. 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)~~(3)] 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)~~(5)],

(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 ~~(e)(3)~~ (f)(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]

530:10-17-76. Senior Undergraduate Program

(a) **Eligibility.** The Senior Undergraduate Program consists of positions for a term of up to 24 months for students who are currently enrolled in institutions of higher education and

working toward a baccalaureate degree. [74:840-3.4(A)(2)]. No person is eligible to participate in the Senior Undergraduate Program for more than **2** years. To be considered for eligibility determination, applicants shall have at least **90** semester hours of undergraduate coursework with at least a **2.5** grade point average on a **4.0** scale [74:840-3.4(A)(2)]. Applicants shall follow the procedures in 530:10-17-77 for eligibility determination.

(b) **Conditions of employment.** Participants in the Senior Undergraduate 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 baccalaureate degrees during each fall and spring semester until completion of all undergraduate 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.

(c) **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 baccalaureate degree, until completion of all undergraduate 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 **4** clock hours of job related training for Senior Undergraduate Interns 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 Senior Undergraduate 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 as prescribed by the Administrator;

(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 astate employee [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, or the Senior Undergraduate Intern, and the internship faculty member. The form provides information regarding employment, benefits,

training, work schedule, 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.

[OAR Docket #10-801; filed 5-7-10]

TITLE 530. OFFICE OF PERSONNEL MANAGEMENT
CHAPTER 15. VOLUNTARY PAYROLL DEDUCTION

[OAR Docket #10-802]

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PERMANENT final adoption
RULES:
Subchapter 1. General Provisions
530:15-1-1 [AMENDED]
530:15-1-2 [AMENDED]
530:15-1-5 [AMENDED]
530:15-1-6 [AMENDED]
530:15-1-7 [AMENDED]
530:15-1-12 [AMENDED]
Subchapter 3. Administrative Provisions
530:15-3-7 [AMENDED]
530:15-3-7.1 [AMENDED]
530:15-3-8 [AMENDED]
530:15-3-14 [AMENDED]
Subchapter 5. Complaints and Hearings
530:15-5-8 [AMENDED]
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The Administrator of the Office of Personnel Management; 74 O.S., § 840-1.6A and 62 O.S. §34.70.
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530:15-1-7 [AMENDED]
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The proposed amendments to 530:15-1-1; 530:15-1-2; 530:15-1-5; 530:15-1-6; 530:15-1-7; 530:15-1-12; 530:15-3-7; 530:15-3-8; 530:15-5-8 are necessary to correct the statutory citations to the Voluntary Payroll Deduction statutes that were re-codified during the 1st Session of the 52nd Oklahoma Legislature and to make emergency provisions permanent. Proposed amendments are also necessary to 530:15-1-2 and 530:15-3-14 due to the recent enactment of SB 384. The proposed amendments to 530:15-3-7.1 are necessary due to the recent enactment of SB 670 and to amend the Voluntary Payroll Deduction Rules to be consistent with the statutory authority and to make emergency provision permanent.
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 JUNE 11, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

530:15-1-1. Purpose

The rules in this Chapter provide procedures for implementation of voluntary payroll deductions for employee association dues, educational employee organizations, employee association foundation contributions, payments to credit unions, banks, or savings associations, payments to supplemental insurance and retirement plans, payments to a college savings account, and subscriptions to Oklahoma Today magazine, as authorized for state employees by Section ~~7.10~~34.70 of Title 62 of the Oklahoma Statutes. Other types of voluntary payroll deductions (such as those for salary adjustment agreements under subsection B(4) of Section ~~7.10~~34.70, U.S. Savings Bonds or charitable gifts) are not addressed by the rules in this Chapter.

530:15-1-2. Definitions

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

"Administrator" means the chief administrative officer of the Office of Personnel Management, an officer of the State of Oklahoma appointed by the Governor pursuant to Section 840-1.6A of Title 74 of the **Oklahoma Statutes**, and authorized to establish procedures for administration of voluntary payroll deductions by Section ~~7.10~~34.70. The term, as used in this Chapter, includes employees of the Office of Personnel Management to whom the Administrator has lawfully delegated authority to act on his or her behalf.

"Appointing Authority" means the chief administrative officer of an agency. As the term is used in the Voluntary Payroll Deduction Rules, the term includes employees of an agency to whom the Appointing Authority has lawfully delegated authority to act on his or her behalf.

"Complaint" means a grievance with respect to any matter relevant to the Administrator's duties under Section ~~7.10~~34.70.

"Complainant" means a person or an organization that has submitted a complaint.

"Declaratory ruling" means an explanation of a rule or order and its applicability to a particular matter.

"Dues-paying" means, with respect to a member of an employee association, the member is either currently paying dues or has provided a valid authorization to have such dues withheld from pay and remitted to the association. ~~[62:7.10B)(5)]~~ [62:34.70 (B)(5)]

"Employee association" means a formal and continuing affiliation of state employees with the principle objective of speaking for and benefiting their interests as employees, in which membership is restricted to state employees but unrestricted as to the geographic location of their duty stations, and which has at least 2,000 dues-paying members. An employee organization also falls within this definition.

"Member" means:

(A) with respect to a credit union, a shareholder; and

(B) with respect to a bank or savings association, an account holder; and,

(C) with respect to an employee association, a person who has sought and been granted recognition as one of those within the field of membership as defined by the association's governing instruments.

"Participation" means the total number of state employees reported to the Office of Personnel Management for which amounts withheld from pay for a given month were remitted pursuant to employee authorization to a single billing unit as identified by its Federal Employer (Tax) Identification Number.

"Party" means any person, employee association, educational employee organization, credit union, bank, savings association or insurance organization that is the subject of, or requests, action by the Administrator in connection with any matter relevant to the Administrator's duties under Section ~~7.10~~34.70.

"Product vendor" means any of the following entities approved for state employees' voluntary payroll deduction:

(A) an entity offering a supplemental retirement plan with a minimum participation of **500** state employees;

(B) a private insurance organization with a minimum participation of **500** state employees for supplemental life, accident, or health insurance;

(C) a private insurance organization with a minimum participation of **500** state employees for legal services;

(D) the Oklahoma Tourism and Recreation Department as publisher of Oklahoma Today magazine.

"Provided for by the State" means:

(A) for insurance purposes, the basic health, life, dental, or disability plan or any other such insurance a state agency is authorized to provide for its employees as evidenced by financial participation in those policies or a group policy(s) the agency has negotiated as a basic employment benefit; and

(B) for retirement purposes, any state retirement system, deferred compensation program (commonly referred to as deferred annuities), or other retirement plan(s) a state agency is authorized to provide for its employees as evidenced by financial participation in those plans.

"Section ~~7.10~~34.70" means Section ~~7.10~~34.70 of Title 62 of the **Oklahoma Statutes.**

"State agency" means any office, department, board, commission, or institution of the State of Oklahoma."

"State employee" means any employee of a state agency.

"Supplemental" means:

(A) for insurance purposes, life, accident (including income continuation during disability), legal, and health insurance policies not provided for by the State; and

(B) for retirement purposes, plans that provide retirement income benefits and are not provided for by the State. In recognition of the powers conferred upon state institutions of higher education by Section 3905 of Title 70 of the **Oklahoma Statutes**, the Administrator will follow such institutions' decisions as

to whether an insurance policy or retirement plan is a basic or a supplemental employee benefit.

530:15-1-5. Construction

The rules in this Chapter shall be construed liberally to effectuate the purposes and provisions of Section ~~7.10~~34.70.

530:15-1-6. Determinations of fact and conclusions of law

All determinations of fact or conclusions of law shall be made by the Administrator. The Administrator may initiate actions when he determines it is necessary to do so in order to accomplish the objectives of Section ~~7.10~~34.70, and to carry out his duties thereunder. The Administrator may appoint one or more employees or officers to assist him in executing such duties.

530:15-1-7. Filing and inspection of documents

(a) Requests for declaratory rulings, applications for administrative actions, complaints or other communications regarding any matter relevant to the Administrator's duties under Section ~~7.10~~34.70 must be directed to the Administrator, Office of Personnel Management, 2101 N. Lincoln Blvd., Oklahoma City, OK 73105-4904; telephone (405) 521-2177.

(b) Except as provided elsewhere by the rules in this Chapter, no particular form is required. Requests for blank forms and general information may be directed to the Office of Personnel Management, Attention: Financial Management Services, at the same address and telephone number.

(c) A document that is required to be filed may be sent by mail or hand-delivered within the time limit, if any, for such filing. The date on which it is received at the Office of Personnel Management shall be deemed to be the date of filing. The document must be signed by the party to the action, by a duly authorized representative of the party, or by the party's attorney; provided, however, an application by a credit union, bank, savings association, employee association, or educational employee organization for approval or renewal of payroll deduction status must be signed by an officer of the organization. The signature of the person signing the document constitutes a certification that such person has read the document and has personal knowledge of the facts set forth therein; that every statement contained in the instrument is true and correct and no such statements are misleading; and that the document is not interposed for delay. If any document submitted is not signed or is signed with intent to defeat the purposes of the rules in this Chapter, it may be stricken as sham and false and the Administrator may proceed as though the document had not been served or filed.

(d) If a party has designated an attorney to represent it, the Administrator shall communicate with the party through the attorney, and consider that the attorney can act for and bind the party.

(e) A document a party has filed may be amended, upon the party's written request and in the discretion of the Administrator, at any time prior to final action. If amended, the document shall be effective as of the date of the original filing.

(f) If a document that has been filed is not in substantial conformity with the applicable rules as to the contents thereof or is otherwise insufficient, the Administrator, on his own initiative or upon request of a party, may strike or dismiss such document, or require its amendment.

(g) All documents filed with the Administrator shall be retained in the files of the Office of Personnel Management in accordance with the Records Management Act, Section 201 through 216 of Title 67 of the **Oklahoma Statutes.** The Administrator may permit the withdrawal of original documents upon submission of properly authenticated copies to replace such documents.

(h) Any document submitted to the Administrator with respect to a matter under Section ~~7.10~~34.70 and that is not exempt from public disclosure; any form that may be adopted by the Administrator; all rules, written statements of policy or interpretation; and all final orders, decisions and opinions formulated or used by the Administrator are available for public inspection.

530:15-1-12. Requests for declaratory rulings

(a) A party may request that the Administrator issue a declaratory ruling with regard to any matter relating to the party's interests and involving the administration of Section ~~7.10~~34.70. A request for declaratory ruling must be in writing and signed in accordance with the rules in this Chapter. No particular form is required. A request for declaratory ruling shall include the following:

(1) The name and address and organizational affiliation, if any, of the requesting party, and the title of any representative filing the request; and

(2) A clear and concise explanation why a declaratory ruling is needed, including such facts, names, citations of law and administrative rules that may be relevant to the matter.

(b) The Administrator will acknowledge receipt of the request for declaratory ruling within **15** days after receipt. If the request is repetitive, concerns a matter that in the Administrator's judgment is inappropriate for a declaratory ruling, or concerns a matter beyond the Administrator's scope of authority, the request may be denied and the party so advised.

(c) If a request for declaratory ruling names or will directly, materially and adversely affect another party, the Administrator shall provide the other party with written notice and afford such party an opportunity to respond in writing. Any response must be filed with the Office of Personnel Management within **15** days after the date notice was mailed.

(d) The Administrator will consider a request for declaratory ruling and issue a decision within **30** days after receipt, unless additional time is deemed necessary in which event the requestor will be so advised and given the reasons therefor.

SUBCHAPTER 3. ADMINISTRATIVE PROVISIONS

530:15-3-7. Dues for employee associations

(a) An employee association other than one specifically authorized payroll deduction for its dues by statute may request such status. The request must be made by filing a completed Form VPD-1 and providing the Administrator with information to show it is a statewide association limited to state employee membership and has at least 2,000 dues-paying members. ~~[62:7.10B)(5)]~~ [62:34.70 (B)(5)]

(b) Either of the following may be submitted as evidence that an employee association has at least (2,000) dues-paying members.

(1) Attestation by an independent public accountant or certified public accountant that the association had at least (2,000) members at the time of the accountant's examination of membership records, all of whom either were currently paying dues or had signed valid authorizations for payroll deduction of dues. The examination must have taken place within the **60** days preceding the date of application for payroll deduction status.

(2) Photocopies of membership application cards, showing the association name, date of membership application, member's name and address, employing state agency and signature authorizing payroll deduction of dues. These must be accompanied by an affidavit signed by a duly authorized representative of the association, attesting that all persons for whom cards are submitted are current members. Cards shall be considered valid if the dates thereon, and other evidence provided to the Administrator, indicate a regularity of continuing interest by the employees signing the cards.

(c) The Administrator may require an association that has previously been granted payroll deduction status to file a completed Form VPD-1 and to certify or demonstrate it continues to be a statewide association limited to state employees with at least (2,000) dues-paying members. The Administrator may utilize the State's payroll records to satisfy himself that there continue to be at least (2,000) dues-paying members.

(d) As evidence an employee association is a "statewide" organization in which membership is limited to state employees, the association must submit a copy of its governing instruments, demonstrating that membership is both:

(1) restricted to state employees, and

(2) open to state employees regardless of the geographic location of their duty stations.

530:15-3-7.1. Contributions to employee association foundations

(a) ~~An~~Any statewide employee association limited to state employee membership with a minimum membership of two-thousand (2,000) dues-paying members ~~authorized payroll deduction for its dues by statute or by the Administrator according to 530:15-3-7~~ may request payroll deduction for contributions to its foundation organized under 26 U.S.C., Section 501(c)(3). The request must be made by filing a completed form VPD-1 with the Administrator. The form shall be accompanied by:

(1) a copy of the determination by the Internal Revenue Service that the foundation is exempt from federal income tax as an organization described in section 501(c)(3) of the Internal Revenue Code; and

(2) a statement on the foundation's letterhead signed by an officer of the foundation indicating the foundation is affiliated with the employee association submitting the request.

(b) The Administrator may verify that an association has previously been granted payroll deduction status for membership dues and continues to be eligible by statute or under 530:15-3-7.

(c) After a foundation has been authorized payroll deduction status, the employee association shall be responsible for immediately notifying the Administrator in writing of any changes in the foundation's eligibility for payroll deduction status. This shall include but not be limited to copies of any communications from the Internal Revenue Service concerning the foundation's exemption from federal income tax as an organization described in section 501(3)(c) of the Internal Revenue Code. The Administrator may require an association that has previously been granted payroll deduction for its association to file a completed VPD-1 and to submit evidence that it continues to possess a 501(c)(3) exemption from the Internal Revenue Service.

530:15-3-8. Credit unions, banks and savings associations

A credit union, bank or savings association having an office in this state may request payroll deduction status. The request must be made by filing a completed Form VPD-1 and providing the Administrator with information to show at least one branch office location in the state of Oklahoma. ~~[62:7.10(A)(1)]~~ [62:34.70 (A)(1)]

530:15-3-14. Procedure for requesting Voluntary Payroll Deduction

(a) A request by a state employee for voluntary payroll deduction for the payment of premiums for supplemental life, accident, and health insurance, insurance premiums for legal services, premiums or payments for retirement plans, payment of insurance premiums due to a private insurance organization, which is regulated by the State Insurance Commission, for an Oklahoma Long-Term Care Partnership Program approved policy pursuant to the Oklahoma Long-Term Care Partnership Act, salary adjustment agreements included in the flexible benefits plan, contributions to the Oklahoma College Savings Plan, membership dues in any statewide educational organization or association, payments to banks, credit unions, savings associations and subscriptions to the Oklahoma Today magazine, must be made in writing to the employing state agency. The request must include the employee's signature.

(b) A request by a state employee for voluntary payroll deduction for the payment of membership dues in an employee association may be made as described in Subsection (a) or may be made via online or electronically submitted forms. The employee association shall verify that the online or electronically submitted form accurately reflects the request of the state employee via email or another method approved by the Office

of Personnel Management, and shall forward a copy of such verification and membership application to the employing agency for processing.

(c) All forms for employee requests for voluntary payroll deduction, whether paper or electronic format, shall include at a minimum the employee's name, Social Security number, the amount of the voluntary payroll deduction, the vendor's name, and if applicable, the approved policy form number.

SUBCHAPTER 5. COMPLAINTS AND HEARINGS

530:15-5-8. Hearings

(a) The Administrator may hold a hearing on any matter relating to the administration of Section ~~7.10~~34.70. The Administrator or a person designated by the Administrator as the hearing officer may conduct the hearing.

(b) The following procedures for hearings will be followed except as may be required by the provisions of Article II of the Administrative Procedures Act, Sections 309 through 323 of Title 75 of the **Oklahoma Statutes**:

(1) The Administrator shall give at least **10** days notice of a hearing. Notice shall be made:

(A) by posting a meeting announcement at the premises of the Office of Personnel Management; and

(B) by mail to persons who have requested that they receive notice of a hearing or who, in the judgment of the Administrator, may be affected by the subject of the hearing.

(2) A meeting announcement shall include the time, date and place for the hearing, and a description of the subject of the hearing. Unless the meeting announcement contains other instruction, the meeting will begin with introductory remarks, followed by an explanation of the subject, and an opportunity for attendees to make oral comments. Oral presentations by an individual attendee, or by a group of attendees who represent a common interest, may be limited to **30** minutes. Ten minutes additional time may be allowed if necessary for responses. Written comments are encouraged but not required.

(c) This Section does not apply to meetings and hearings which are subject to the Open Meeting Act, Section 301 through 314 of Title 25 of the **Oklahoma Statutes** or to Article I of the Administrative Procedures Act, Sections 250.2 through 308.2 of Title 75 of the **Oklahoma Statutes.**

[OAR Docket #10-802; filed 5-7-10]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES CHAPTER 1. ADMINISTRATIVE OOPERATIONS

[OAR Docket #10-748]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Administrative Components of the Department
612:1-3-2. The Director of Rehabilitation Services [AMENDED]
612:1-3-2.1. The ~~Deputy Director~~Chief of Staff of Rehabilitation Services [AMENDED]
612:1-3-3. The Division Administrators/School Superintendents [AMENDED]
612:1-3-8.1. Executive officers [AMENDED]
612:1-3-10. Final signature authority [AMENDED]
Subchapter 5. Program Divisions Within the Department
612:1-5-4.2. Financial Services Division (FSD) [NEW]
Subchapter 17. Availability of Information, Scope and Description of Open Meetings
612:1-17-1. Access to DRS records [AMENDED]

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N/A

ANALYSIS:
The agency no longer has a Deputy Director and is not likely to ever have one again. Those duties have been assigned to the Chief of Staff. The agency is creating a new division to manage our budget and finances. The new division is the Financial Services Division.

CONTACT PERSON:
Ray Leard, Administrative Program Officer, Policy Development, Department of Rehabilitation Services, 3535 N.W. 58th, Suite 500, Oklahoma City, OK 73112 (405) 951-3406

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, 2010:

SUBCHAPTER 3. ADMINSTRATIVE COMPONENTS OF THE DEPARTMENT

612:1-3-2. The Director of Rehabilitation Services

(a) The Director of Rehabilitation Services, as the chief administrative and executive officer of the Department of Rehabilitation Services (DRS), is charged with the responsibility for day-to-day direction of the activities necessary for DRS to attain its mission as established by Title 74, Section 166.1 et seq. of Oklahoma State Statute. The work of the Director is overseen by the Commission for Rehabilitation Services.

(b) The Director directly supervises the ~~Deputy Director~~Chief of Staff, the Chief Fiscal Officer, the Public Information and External Relations Officers, and the Civil Rights Administrator.

(c) The Director's duties include:

(1) assuring that all of DRS is working toward its mission and the goals established by the Commission through aggressive implementation of the planning and budgeting system;

(2) serving as staff to the Commission for Rehabilitation Services, providing necessary input for decision-making and assuring that actions approved by the Commission are carried out;

(3) serving as ex officio member to the Rehabilitation Advisory Council, and consultant to the Independent Living Council;

(4) developing and maintaining cooperative relationships with lawmakers and other officials, both federal and state, to assure the fulfillment of DRS's mission;

(5) maximizing all available resources for the delivery of services to the clients DRS is charged to serve;

(6) serving as the chief spokesperson for DRS and as an advocate for the clients it serves;

(7) assuring the coordination of services with other state agencies; and,

(8) selecting staff capable of carrying out the DRS mission for the areas immediately under the Director's supervision, establishing job descriptions and specifications for each of those positions, delegating authority to complete duties assigned and overseeing the accomplishment of those assigned responsibilities.

612:1-3-2.1. The ~~Deputy Director~~ Chief of Staff of Rehabilitation Services

(a) The ~~Deputy Director~~ Chief of Staff of Rehabilitation Services assists the Director of the Department in fulfilling the chief administrative and executive responsibilities for day-to-day direction of the activities necessary for DRS to attain its mission as established by Title 74, Section 166.1 et seq. of Oklahoma State Statute. The work of the ~~Deputy Director~~ Chief of Staff is overseen by the Director of the Department of Rehabilitation Services. In the Director's absence, the work of the ~~Deputy Director~~ Chief of Staff is overseen by the Commission for Rehabilitation Services.

(b) To the extent deemed necessary and prudent by the Director, or in the Director's absence, the ~~Deputy Director~~ Chief of Staff supervises the Division Administrators for Vocational Rehabilitation Services, Visual Services, Disability Determination, Financial Services Division, ~~and~~ Management Services ~~except for the Budget and Finance Unit~~, and the Superintendents of the School for the Blind and the School for the Deaf. In the Director's absence, the ~~Deputy Director~~ Chief of Staff also supervises the Public Information and External Relations Officers, the Chief Fiscal Officer, and the Civil Rights Administrator.

(c) The ~~Deputy Director's~~ Chief of Staff duties include:

(1) assuring that all of DRS is working toward its mission and the goals established by the Commission and the Director through aggressive implementation of the planning and budgeting system;

(2) serving as staff to the Commission for Rehabilitation Services at the direction of, or in the absence of, the Director, providing necessary input for decision-making and assuring that actions approved by the Commission are carried out;

(3) developing and maintaining cooperative relationships with lawmakers and other officials, both federal and state, to assure the fulfillment of DRS's mission;

(4) maximizing all available resources for the delivery of services to the clients DRS is charged to serve;

(5) serving as a spokesperson for DRS and as an advocate for the clients it serves;

(6) assuring the coordination of services with other state agencies; and,

(7) carrying out such other duties and assignments the Director, or in the Director's absence, the Commission deems necessary and prudent to attain the mission of DRS; delegating authority to complete duties assigned, and overseeing the accomplishment of those assigned responsibilities.

612:1-3-3. The Division Administrators/School Superintendents

The Division Administrators/School Superintendents within the Department of Rehabilitation Services have responsibility for the day-to-day operational direction of the programmatic aspects of DRS, including the field work. The Division Administrators/School Superintendents supervise the various administrators of program units. The duties of the Division Administrators include:

(1) assuring program integrity across all programs;

(2) coordinating the planning and budgeting system;

(3) coordinating the delivery of all field services;

(4) providing support for all field offices;

(5) exploring and developing resources for programs, including coordination with state and federal officials;

(6) serving as arbitrators for programmatic and field issues;

(7) coordinating field and program issues with administrative functions; and,

(8) providing liaison between DRS and members of the Oklahoma Legislature, the Governor, and other state officials as requested by the Director and/or ~~Deputy Director~~Chief of Staff.

612:1-3-8.1. Executive officers

The executive officers in (1) through (5) report directly to the Department of Rehabilitation Services Director.

(1) **~~Deputy Director~~ Chief of Staff.** The ~~Deputy Director~~ Chief of Staff ~~of Rehabilitation Services~~ assists the Director of the Department in fulfilling the chief administrative and executive responsibilities for day-to-day direction of the activities necessary for DRS to attain its mission as established by Title 74, Section 166.1 et seq. of Oklahoma State Statute. The work of the ~~Deputy Director~~ Chief of Staff is overseen by the Director of the Department of Rehabilitation Services. In the Director's absence, the work of the ~~Deputy Director~~ Chief of Staff is overseen by the Commission for Rehabilitation Services.

(2) **Chief Fiscal Officer.** The Chief Fiscal Officer is ~~the administrator of the Budget and Finance Unit. This Unit is responsible for development and administering the Department's budget, Federal and general accounting, revenue, and claims processing~~ responsible for the direction and oversight of the Department's fiscal operations, including finance, general and federal accounting, budgeting, administration and control of financial information systems, and reporting activities.

(3) **Civil Rights Administrator.** The Civil Rights Office is responsible for preparing the annual Affirmative Action Plan; ensuring that DRS is in compliance with all applicable state and federal laws, executive orders and other policies regarding discrimination based on race, sex, national origin, age, religion, and/or disability. The Civil Rights Administrator conducts investigations of discrimination and/or 504, ADA compliance complaints for Department employees and clients.

(4) **External Relations Officer.** The External Relations Officer coordinates The Department's legislative initiatives and monitors legislative actions affecting the Department.

(5) **Public Information Administrator.** The Public Information Administrator coordinates the dissemination of public information about DRS. This is accomplished through news releases, a Department newsletter, publications in appropriate media formats, and other public relations activities. The Public Information Office is also responsible for producing the Department's annual report.

612:1-3-10. Final signature authority

The Department of Rehabilitation Services recognizes the importance of efficient processing of resource and operations approval requests. At the same time, the Department must assure sufficient oversight of resource allocation in order to fulfill its obligations as a steward of public funds. The Department has therefore established a signature authority listing to delineate final approval levels for resource and operations approval requests. With regard to signature authority on contracts, all expenditures must be consistent with DRS's budget categories as approved by the Commission. Delegation of final signature authority is limited to the next lower administrative level unless approved in writing by the Director. The administrator is to notify the appropriate administrative programs of delegations. Administrators have authority to approve actions within their areas of responsibility at all administrative levels below their own. The requests listed in (1) through (9) of this Subsection must continue to be reviewed and approved by the appropriate staff before presentation to the individual with final signature authority. There are additional resource and operations approvals unique to each administrative area that are stated in the policies established for that administrative area.

(1) **Director's signature.** The Director has final signature authority for items listed in (A) through (E) of this Paragraph.

(A) Sole source contracts.

(B) Initial contracts for $250,000 or more.

(C) Notices of personnel action (may be delegated).

(D) Leave without pay requests for 90 days or more.

(E) Other actions as required by executive order, statute, etc.

(2) **~~Deputy Director~~ Chief of Staff.** ~~Deputy Director~~ The Chief of Staff has final signature authority for items listed in (A) through (C) of this Paragraph.

(A) Initial contracts between $100,000 and $250,000 on a case by case basis and upon written authority of the Director.

(B) Initial contracts or interagency agreements which obligate the entire Department or more than one division.

(C) New brochures, forms, publications (electronic or printed), and videos produced for more than one division.

(3) **Division Administrator.** Division Administrators have final signature authority for items listed in (A) through (K) of this Paragraph.

(A) Initial contracts for less than $100,000.

(B) New or revised interagency agreements involving the division.

(C) Administrative purchases costing $10,000 or more (may be delegated). Computer purchases must be co-signed by the Administrator for Information Services.

(D) Requests for employee in-state travel (may be delegated).

(E) Requests for out-of-state employee travel.

(F) Final decisions for employee grievance resolution, other than discrimination complaints, and for adverse action after review by Human Resources.

(G) Leave without pay requests for less than 90 days.

(H) Brochures, forms, publications (electronic or printed), and videos produced for the division.

(I) Requests for internships or practicums for respective division.

(J) Memos for general distribution to the division.

(K) Grant proposals.

(4) **Executive and MSD Administrators.** Executive and MSD Administrators have final signature authority for items listed in (A) through (F) of this Paragraph.

(A) Office supply orders.
(B) Reorder of existing printed materials.
(C) MSD Unit administrative purchase requisitions under area of responsibility up to $10,000. Computer purchases must be co-signed by the Administrator for Information Services.
(D) Administrative memos under area of responsibility.
(E) Policy Transmittals by the Administrator for Policy Development and Programs Standards.
(F) Requests for employee in-state travel.

(5) **Field Coordinators and Program Managers in DVR and DVS.** The Field Coordinators or Program Managers in Vocational Rehabilitation Services and Visual Services Divisions have final signature authority for administrative purchases up to $10,000. Computer purchases must be co-signed by the Administrator for Information Services.

(6) **Program Managers in DVR and DVS.** Program Managers have final signature authority for items listed in (A) through (B) of this Paragraph.
(A) Office supply requisitions other than those available on the electronic ordering system.
(B) Reorder of existing printed materials.

(7) **Superintendents at OSB and OSD.** Superintendents have final signature authority for items listed in (A) through (J) of this Paragraph for the respective school.
(A) Initial contracts for less than $100,000.
(B) Interagency agreements involving only the school.
(C) All administrative and educational purchases. Computer purchases must be co-signed by the Administrator for Information Services.
(D) Requests for all employee travel.
(E) Final decisions for adverse action after review by Human Resources.
(F) Final decisions for grievance resolutions, other than discrimination complaints.
(G) Leave without pay requests for less than 90 days.
(H) Requests for internships or practicums.
(I) Brochures, forms, publications (electronic or printed), and videos produced for the school.
(J) Grant proposals.

(8) **Supervisors at OSB and OSD.** Supervisors at OSB and OSD have final signature authority for items in (A) through (B) of this Paragraph for the respective school.
(A) Office supply orders.
(B) Reorder of existing printed materials.

(9) **Program Managers, Disability Determination Division.** Program Managers at the Disability Determination Division have final signature authority for the following items in (A) through (B) of this Paragraph.
(A) The Program Manager responsible for budgets, contracts, and purchases approves administrative purchases under $10,000. Computer purchases must be co-signed by the Administrator for Information Services.
(B) Reorder of existing printed materials.

SUBCHAPTER 5. PROGRAM DIVISIONS WITHIN THE DEPARTMENT

612:1-5-4.2. Financial Services Division (FSD)

The Financial Services Division provides quality financial management and administration of all agency budgeting, federal and general accounting, revenue, claims processing, and reporting for our customers.

SUBCHAPTER 17. AVAILABILITY OF INFORMATION, SCOPE AND DESCRIPTION OF OPEN MEETINGS

612:1-17-1. Access to DRS records

(a) **Rights.** The Oklahoma Open Records Act is codified in 51 O.S. 24A.1 through 24A.18. In general the purpose of this Act is to ensure and facilitate the public's right of access to, review and copying of governmental records. The scope of the records to be maintained is expanded under the Act to include completed records of all business and financial transactions. The description of records to be maintained specifically includes books, photographs, microfilm, computer tapes or disks, video records, or "other material regardless of physical form or characteristic".

(b) **Information not subject to release.** This Act does not apply to records specifically required by law, both Federal and State, to be kept confidential. In addition to restrictions on release of information protected by rules, records not to be disclosed include: records subject to privileges such as attorney-client and physician-patient; personal notes prepared for one's own use in making a decision or recommendation, except such material relating to budget requests prior to taking action; propriety information relating to bids prior to publication or opening, computer programs and software, appraisal for awarding contracts prior to the award; the prospective locations of private businesses if disclosure would give an unfair advantage (unless the location is otherwise part of a public record such as license application); personal communications with a public official in the exercise of Constitutional rights (to the extent necessary to protect the person's identity); student records except for director information; documents provided by Federal agencies which are subject to limitations on disclosure; and information related to research, the disclosure of which could affect the conduct or outcome of the research, the ability to patent; or copyright the research or any other proprietary rights in the research or the results of the research. The Act provides that personnel records may be kept confidential if they relate to a personnel investigation/disciplinary action or release would be a clearly unwarranted invasion of privacy.

(c) **Exception.** "Record" does not mean non-governmental personal effects, unless public disclosure is required by other laws or regulations, personal financial statements submitted to a public body for the purpose of obtaining a license, permit, or

for the purpose of becoming qualified to contract with a public body.

(d) **Information subject to release.** Personnel records that are public include the application of a person who becomes an employee, gross receipt of public funds, dates of employment, title or position, and final disciplinary action. All other records not falling within the descriptions given in Subsection (b) of this Section, regardless of physical form, are releasable under the Open Records Act. It is possible that records will contain material that is both open and confidential. As an example, a client's records could have medical information from the Veterans Administration. When this occurs, care should be taken to remove the confidential material.

(e) **Access to records.** Access to records shall not be denied because another division or public official is using or has taken possession of such records for investigatory purposes or has placed the records in an investigation file.

(f) **Inquiries.** Persons requesting the review of copies of records are to submit the request in writing. The written request must include: a description of the requested records; how the records are to be used, such as in the public interest, news media, research, commercial purposes, etc.; and the requestor's name and address.

(g) **Fee exclusions and fees.** Provisions for copying and search fees are contained in the statute, with these exceptions being noted: no copy fee is charged to other public entities, to applicants, recipients or their representatives, or employees or former employees seeking information from their case file or employment records; and no search fee is charged to news media, schools, authors, or "taxpayers seeking to determine whether those entrusted with the affairs of its government are honestly, faithfully, and competently performing their duties as public servants." The fees listed in (1) - (4) of this Subsection may stand alone or be charged in combination. For example, a person may be charged a search fee in addition to a fee for photocopying.

(1) **Fees for photocopying.** The Department has established a fee schedule for documents having the dimensions of 8 1/2 x 14 inches or smaller; if less than 10 pages, 25 cents per page, between 10 and 100 pages, 10 cents per page, and over 100 pages, 5 cents per page, or a maximum of one dollar ($1.00) per copied page for a certified copy.

(2) **Fees for search.** Requests that are for a commercial purpose or clearly would cause excessive disruption of office function will be charged a search fee of $25.00 per hour for staff time spent in the search.

(3) **Fees for other types of reproduction.** Requests for computer runs, microfilming or reproduction other than photocopying, will be charged at the cost to the Department of duplicating the information involved. Such requests are to be forwarded to the State Office where the fee will be developed with the appropriate division.

(4) **Payment of fees.** All fees are paid prior to delivering the copies, and if the request is for search only, the fee is paid before the person is allowed to review the material. All fees are paid by check or money order; cash is not accepted. The fee payment is transmitted to the State Office, Attention ~~Budget and Finance Unit~~ Financial Services Division. In addition, a receipt is to be given upon payment. A copy of the manual material is maintained to explain the fee schedules to interested persons.

(h) **Penalties and appeals.** As indicated, the law generally requires the production and copying of records. A person may file suit or appeal to obtain records. Also, an employee is subject to a criminal action and disciplinary action for "willfully" withholding information that should not have been withheld. On the other hand, no damages may be awarded for release of information. Clearly, the law favors release. If a person wishes to appeal a denial of access to records, within ten days of such denial a letter may be submitted to: Director of Rehabilitation Services, Open Records Act Appeal, 3535 N.W. 58th Street, Suite 500, Oklahoma City, Oklahoma 73112.

[OAR Docket #10-748; filed 5-4-10]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES
CHAPTER 3. MANAGEMENT SERVICES DIVISION

[OAR Docket #10-749]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 1. General Provisions
612:3-1-3. Functions of the division [AMENDED]
Subchapter 3. Human Resources Unit
Part 3. Human Resources Management Section - Personnel Programs
612:3-3-20. Department of Rehabilitation Services recruitment and selection plan [AMENDED]
Subchapter 5. Policy Development and Program Standards
Part 3. Policy Development
612:3-5-12. Policy Development [AMENDED]
612:3-5-13. Drafting of new or revised policy [AMENDED]
Part 5. Program Standards
612:3-5-30. Vocational Rehabilitation and Visual Services compliance reviews [NEW]
AUTHORITY:
The Oklahoma Commission for Rehabilitation Services; Rehabilitation Act, United States Code Title 29, sections 701 through 791; Oklahoma Statute Title 74, Section 166.1 et seq.
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N/A
ANALYSIS:
The changes to Subchapter 3 are necessary due to the Merit rule change regarding the Optional Program for Hiring Applicants with Disabilities; the OPM on-line Applicant System; and the AG's recommendation that agencies not use the Fair Employment Practices Act applicant list. The changes to Subchapter 5 are necessary in order to appoint a different person as liaison to the Office of Administrative Rules; changing Deputy Director to Chief of Staff; and moving compliance reviews out of the Vocational Rehabilitation division and back into the Management Services division.
CONTACT PERSON:
Ray Leard, Administrative Programs Officer, Policy Development, Department of Rehabilitation Services, 3535 N.W. 58th, Suite 500, Oklahoma City, OK 73112 (405) 951-3406

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, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

612:3-1-3. Functions of the division

The division of Management Services provides all components of the Department administrative and programmatic support including ~~budget and finance,~~ human resources, purchasing, contracts, property management, material management, information services, policy management, ~~and~~ program standards and fund raising.

SUBCHAPTER 3. HUMAN RESOURCES UNIT

PART 3. HUMAN RESOURCES MANAGEMENT SECTION - PERSONNEL PROGRAMS

612:3-3-20. Department of Rehabilitation Services recruitment and selection plan

(a) **Method of application.** All applicants who are permanent classified employees, or former permanent classified state employees eligible for reinstatement to the classified service, shall submit a completed OPM Personal Data Summary Sheet form for the position to the DRS Human Resources Unit or other designated location no later than the closing date and time stated in the posted notice. DRS does not carry over completed Personal Data Summary Sheets from one posting to the next unless specified on the posting. All other applicants for classified positions must apply by means of the method indicated on the vacancy notice. The DRS Human Resources Unit notifies applicants who did not meet minimum education and experience requirements for the position. Applicants may submit additional information to the DRS Human Resources Unit which reflects they meet the minimum qualifications for the position. The Human Resources Unit will submit the additional information to the Office of Personnel Management for review. If the Office of Personnel Management determines that minimum qualification for the position are met, the applicant log may be amended and the applicant given consideration for the position if a final selection has not been made by the selecting official.

(b) ~~**Fair Employment Practices Act (FEPA) and persons with severe disabilities**~~ **Optional Program for Hiring Applicants with Disabilities.** ~~The DRS selecting official may request an OPM certificate for underutilized gender/race groups. If underutilization of a targeted group has been determined in accordance with the Affirmative Action Plan, then a FEPA certificate shall be requested. All applicants~~Applicants ~~on file with the DRS Personnel Office~~ that have been certified as "a person with a severe disability" by the Office of Personnel Management will be included ~~with the DRS applicant log~~ on the Special Appointment/Free Names list through OPM and may be considered along with other qualified internal and external applicants.

(c) **Eligibility for consideration.** The agency may consider external applicants concurrently with internal applicants following closing of the announcement. To be eligible for consideration, applicants must meet the requirements set forth in Paragraphs (1) or (2) of this Subsection.

(1) A permanent classified employee or a former state employee who is eligible for reinstatement must:

(A) submit a completed OPM Personal Data Summary Sheet form for the position to the DRS Human Resources Unit or other designated location no later than the closing date and time specified on the posting notice; and

(B) be certified by the OPM ~~Recruitment~~ Applicant Services Division as meeting the minimum qualifications for the posted Level(s) of the Job Family. However, career progression promotions shall be exempt from this requirement provided that an employee has been in a lower level of the job family for an amount of time equal to the difference in the lengths of the experience requirements of the two levels. This exception shall not apply in any case to entry into a job family or where the next higher level is a supervisory position.

(2) All other applicants for employment may be eligible for consideration through:

(A) an open competitive certificate from OPM;

(B) Certification as a person with a severe disability under 74 O.S. 840-4.12; and/or

(C) Special Disabled Veterans Certification~~; and/or~~.

~~(D) Fair Employment Practices provisions of Merit Rules or State Law.~~

(d) **Factors for consideration.** Paragraphs (1) through (5) establish factors for consideration.

(1) In filling vacancies, the agency will consider factors such as performance appraisals, education, experience, and other qualifications related to the expected ability of an individual to perform the work successfully.

(2) The agency may also post and consider special additional factors such as limiting consideration to permanent classified employees of the DRS, special working conditions that an applicant must be willing to accept and selective qualifications required for a position.

(3) A qualified permanent classified DRS employee will be given preference when the merit, ability, and capacity of that employee is relatively equal to that of applicants from outside DRS as determined by the selection process.

(4) A qualified permanent classified DRS employee with the greatest seniority based upon the last date of continuous DRS employment will be given preference when the merit, ability, and capacity of that employee is relatively equal to other applicants as determined by the selection process.

(5) Consideration may be given to redress underutilization of targeted minority groups. To meet affirmative action goals, all available applicants may be considered.

(e) **Methods for consideration.** Paragraphs (1) through (3) establish methods for consideration. ~~Interview documentation is to be retained for two (2) years by the DRS Human Resources Unit and then destroyed upon receipt of approval from the Archives and Records Commission. If legal action is pending, the information is not to be destroyed until two (2) years after exhaustion of all legal remedies, provided records meet all stipulated retention requirements. Interviewer notes will be maintained in a local applicant file for the position being filled.~~

(1) The methods for consideration may include review of personnel records, applications, ratings, work histories, attendance records, test results, references, and other documents and information relating to a person's eligibility or qualifications.

(2) Applicants may be required to participate in interviews and in other selection procedures.

(3) A personal background investigation, including any civilian and military court records may be conducted.

(f) **Entrance salary.** The entrance salary for any position in the classified service shall be governed by the Merit Rules.

(g) **Probationary period (classified service).** Individuals newly hired into the classified service will serve a probationary period. The probationary period gives the new employee an opportunity to demonstrate the ability to perform the assigned duties of the position. The initial probationary period lasts for one year, except that the Director or ~~Deputy Director~~ Chief of Staff may waive the remainder of the probationary period at any time after a probationary employee has served six months by notifying the employee and the Office of Personnel Management in writing as to the waiver and the reasons for it. The probationary period may not be extended. However, if a probationary employee is granted leave without pay that exceeds 5 working days, the date of the final working day of the probationary period shall be adjusted by the number of working days the probationary employee was on leave without pay in excess of 5 working days. Notification of such leave to the Office of Personnel Management and the employee shall include the scheduled date of the final working day of the adjusted probationary period. The appointment of an employee on probationary status may be terminated whenever the performance is determined to be unsatisfactory. The probationary employee does not have the right of appeal to the Merit Protection Commission when terminated during the probationary period [530:10-11-32]. The employee's immediate supervisor is responsible for carefully observing and evaluating performance. The performance evaluation of a probationary employee must be completed no later than thirty days prior to the end of the probationary period.

(h) **Related employees (classified/unclassified service).** The Department reserves the right to make placements and work assignments of personnel as necessary to eliminate and/or prevent situations in which a position is occupied by a relative of the senior administrator of the relevant division, facility, or office. The Director may waive the prohibitions in this Subsection. The Department prohibits the employment of any person in a position which would result in:

(1) immediate supervision by a relative. Relative is defined to include wife, husband, children, parents, stepparents, parents-in-law, grandchildren, grandparents, brothers, sisters, stepchildren, brothers-in-law, sisters-in-law, sons-in-law, daughters-in-law, aunts, uncles, nieces, nephews, first cousins or any of the above with whom the employee shares a foster relationship; or

(2) two or more relatives reporting to the same immediate supervisor.

(i) **Other employment, prohibition against use of position for personal gain and avoidance of conflict of interest.** Oklahoma Ethics Commission rules [OAC Title 257] are applicable regarding prohibition against use of position for personal use.

(1) Each employee must, during office hours, devote full time, attention, and effort to the Department's business. The employee may not use office hours for private gain.

(2) An employee may accept other employment outside the employee's assigned hours of duty as long as such other employment does not interfere with the employee's work with the Department. If an employee engages in other employment while an employee of the Department, such employment or changes in the employment, as it occurs shall be reported ~~in writing~~ by use of the Report of Other Employment form. Such notification shall be given to the employee's immediate supervisor.

(j) **Final selection.** While others may recruit, screen, consider and make recommendations, the decision on all appointments and changes in classification is tentative until it has the ~~written~~ approval of the Director or designee. No offer of employment may be made until notification of final approval is received from the Personnel Office of the DRS Human Resources Unit.

SUBCHAPTER 5. POLICY DEVELOPMENT AND PROGRAM STANDARDS

PART 3. POLICY DEVELOPMENT

612:3-5-12. Policy Development

(a) Policy Development is charged with assuring that the Department complies with the Administrative Procedures Act. This responsibility includes:

(1) Ensuring that all Department statements of general applicability and future effect that implement, interpret, or prescribe law or policy, or describe the procedures or practice requirements of the Department are promulgated in accordance with the APA.

(2) That the public receives proper notice of the Department's intent to adopt, amend, or revoke rules so that opportunity is provided for public and consumer input during the rulemaking process.

(3) Management of the promulgation process for the Department in an efficient and effective manner that complies with the APA.

(b) The Administrator of the Policy Development and Program Standards Unit, or designee, serves as the Department's liaison to the Office of Administrative Rules in the Office of the Secretary of State. This administrator, or designee also serves as the attestation officer, as delegated by the Oklahoma Commission for Rehabilitation Services, for purposes of 75 O.S., Section 254. An Administrative Officer within Policy Development will be designated as the back-up attestation officer for the Department.

(c) Once a Division or the Executive Office has developed proposed policy and supporting documentation, Policy Development staff will format and prepare the resulting documents for submission to the Commission for action. From that point, Policy Development staff will be responsible for the promulgation process from initial notices through distribution of the adopted policy.

(d) Policy Development staff is responsible for review of Departmental publications to assure consistency with existing policy, and conformance with the APA.

(e) Policy Development staff will manage and maintain Departmental regulations and Rehabilitation Services Administration memoranda and regulations. Copies of State statutes and relevant Federal statutes will also be managed and maintained as directed.

612:3-5-13. Drafting of new or revised policy

(a) The administrators in each division, at each school, and in the executive offices are responsible for keeping informed of the statutes and regulations which govern the operation of programs under their authority. These administrators are also in the best position to know the needs of his or her programs' consumers, staff, and service partners. Each Division Administrator, Unit Administrator, and School Superintendent is therefore responsible for ensuring that Departmental policies for his or her program conform to the requirements of applicable statutes and regulations, and are effective in achieving their program's mission. Whenever possible, drafting of new or revised policies should begin at least twelve months in advance of their intended effective date.

(b) When an administrator, or the Director, decides there is a need to draft new policy, or to amend existing policy, the Unit Administrator, Division Administrator, Superintendent, ~~Deputy Director~~ Chief of Staff or Director will assure that sufficient opportunity for input on the needed changes will be given to individuals and groups as designated by the administrator or Director. The appropriate program administrator will provide the Policy Development staff the reasons for changing policy as well as any budget impact these changes may incur and is to consult with Policy Development staff about the need to arrange for, announce, and hold any public forums. Public comments and responses to them must be submitted to the Policy Development Section for inclusion in the rulemaking record. Policy Development staff assistance in developing a summary of comments and responses is available.

(c) The appropriate program administrator will initiate drafting of policy content through whatever method deemed most effective by the administrator. Policy Development Section staff will provide assistance as requested. The Policy Development Section will be responsible for drafting Departmental policy pages using the content drafts provided by the appropriate program administrator. Once this first draft is completed, Policy Development staff will consult with the appropriate administrator concerning any needed revisions. When these are completed, the draft policy will be distributed to Executive Team members for review and response. Administrators will consider comments and revise drafts as appropriate, providing final draft versions to the Policy Development Section. The appropriate program administrator will determine when the draft policy is ready for distribution to Departmental staff for comment. Staff comment will be obtained as follows:

(1) A memo will be addressed to all Departmental staff advising them that the draft policy is being distributed for comment, and will include:

(A) identification and summary of the draft policy being distributed;

(B) general instructions on where the draft policy can be accessed;

(C) how to submit comments, and the due date for submission of comments; and

(D) where to direct questions about the draft policy.

(2) Policy as drafted by the Policy Development Section will be distributed to each office of the Department (including alternative formats). The Bulletin Board memo will provide instructions for providing comments and where to direct questions about the draft policy. Alternative formats are also to be made readily available.

(3) Comments will be returned to the Policy Development Section where they will be collated, and a summary of them developed. The summary and collated comments will be provided to the appropriate program administrator. The appropriate program administrator will decide on what policy changes to make in response to the submitted comments, if any. The appropriate program administrator will draft responses to the comments, which will at a minimum explain any instance in which staff recommendations were not adopted and will be forwarded to the respective commentator as well as the Policy unit.

(4) Policy Development staff will work with the appropriate program administrator to finalize draft policy. This step will include a final check for consistency with

existing policies, regulations, and applicable statutes. Policy Development staff will obtain authorization from the appropriate program administrator to proceed with promulgation of the draft policy.

(d) When the draft policy pages are submitted to the Policy Development Section for promulgation, the draft policy is then referred to as proposed policy. Policy Development staff will submit the proposed policy and/or notice, including executive summary and resolution, to the Director for review prior to submission to the Commission for discussion or action.

PART 5. PROGRAM STANDARDS

612:3-5-30. Vocational Rehabilitation and Visual Services compliance reviews

(a) Assigned Case Review staff will conduct reviews on a random sample of closed cases to determine if case documentation indicates consumers are being served according to standards established by the Rehabilitation Act and agency policy. Staff will use the instrument currently approved by the Director or designee and will report their findings to appropriate staff on a regular schedule.

(b) Upon request and as other duties allow, Case Review staff will conduct reviews of active cases and will report their findings to appropriate staff within agreed-upon deadlines.

(c) Case Review staff will participate in compliance reviews conducted by RSA as assigned. RSA staff will be responsible for reporting the results of such reviews unless otherwise directed by the Administrator for Policy Development and Program Standards.

[OAR Docket #10-749; filed 5-4-10]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES CHAPTER 5. FINANCIAL SERVICES DIVISION

[OAR Docket #10-750]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 1. General Provisions [NEW]
612:5-1-1. Purpose for Financial Policy [NEW]
612:5-1-2. Mission of the Financial Services Division [NEW]
Subchapter 3. Regulatory Structures [RESERVED]
Subchapter 5. Agency Encumbrances [RESERVED]
Subchapter 7. Agency Expenditures [RESERVED]
Subchapter 9. Agency Budget Activity [RESERVED]
Subchapter 11. Special Accounts [RESERVED]
Subchapter 13. Financial Services Miscellaneous [RESERVED]
AUTHORITY:
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N/A
ANALYSIS:
The agency is creating a new division which will control the budgeting and financial services of the agency
CONTACT PERSON:
Ray Leard, Administrative Programs Officer, Policy Development, Department of Rehabilitation Services, 3535 N.W. 58th, Suite 500, Oklahoma City, OK 73112 (405) 951-3406

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, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

612:5-1-1. Purpose for Financial Policy

The purpose is to set forth the policies and procedures governing the Financial Services Division of the Department of Rehabilitation Services (the agency). Authority for the policies contained herein derive from enabling legislation for the agency, Title 74 O.S. §166.1, et seq., and legislation governing public finance, Oklahoma Statutes Title 62. This is also based upon rules published by the Office of State Finance, Oklahoma Administrative Code Title 260. In good faith, these policies reproduce Office of State Finance Requirements.

612:5-1-2. Mission of the Financial Services Division

The mission of the Financial Services Division is to provide quality financial management and administration of all agency budgeting, federal and general accounting, revenue, claims processing, and reporting for our customers.

SUBCHAPTER 3. REGULATORY STRUCTURES [RESERVED]

SUBCHAPTER 5. AGENCY ENCUMBRANCES [RESERVED]

SUBCHAPTER 7. AGENCY EXPENDITURES [RESERVED]

SUBCHAPTER 9. AGENCY BUDGET ACTIVITY [RESERVED]

SUBCHAPTER 11. SPECIAL ACCOUNTS [RESERVED]

SUBCHAPTER 13. FINANCIAL SERVICES MISCELLANEOUS [RESERVED]

[OAR Docket #10-750; filed 5-4-10]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES CHAPTER 10. VOCATIONAL REHABILITATION AND VISUAL SERVICES

[OAR Docket #10-751]

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RULES:
Subchapter 1. General Provisions
612:10-1-7. Purchase of services and goods for individuals with disabilities [AMENDED]
612:10-1-10. CARF - Vendors [NEW]
Subchapter 3. Client Participation in Cost of Services
612:10-3-5. Basic living requirements [AMENDED]
Subchapter 7. Vocational Rehabilitation and Visual Services
Part 1. Scope of Vocational Rehabilitation and Visual Services
612:10-7-1. Overview of Vocational Rehabilitation and Visual Services [AMENDED]
612:10-7-2. Field Office responsibilities [AMENDED]
612:10-7-3. Client responsibilities [AMENDED]
612:10-7-6. Assessment for determining eligibility [AMENDED]
Part 3. Case Processing Requirements
612:10-7-27. Career planning center services [REVOKED]
612:10-7-28. Vocational evaluation referrals [REVOKED]
612:10-7-29. Vocational evaluation referral process [REVOKED]
612:10-7-30. Supportive services at career planning centers [REVOKED]
612:10-7-32. Production standards [REVOKED]
612:10-7-33. Supervisory caseload reviews [REVOKED]
612:10-7-33.1. Quality Assurance caseload reviews [REVOKED]
Part 5. Case Status and Classification System
612:10-7-47. Application Status [AMENDED]
612:10-7-49. Closed - Not Accepted for Services [AMENDED]
612:10-7-62. Post-Employment services [AMENDED]
Part 9. Actions Requiring Review and Approval
612:10-7-87. Actions requiring supervisor's approval [AMENDED]
612:10-7-88. Actions requiring field coordinator's approval [REVOKED]
Part 11. Physical and Mental Restoration Services
612:10-7-98. General guidelines for physical and mental restoration services [AMENDED]
612:10-7-101. Convalescent care [REVOKED]
612:10-7-102. Dental services [AMENDED]
612:10-7-103. Dialysis or treatment of end-stage renal disease [AMENDED]
612:10-7-104. Drugs and supplies [AMENDED]
612:10-7-105. Hearing aids [AMENDED]
612:10-7-106. Hospitalization [AMENDED]
612:10-7-109. Low vision services [AMENDED]
612:10-7-111. Medical services for individuals under age 21 [REVOKED]
612:10-7-112. Nursing services [AMENDED]
612:10-7-117. Psychiatric and psychological treatment [AMENDED]
Part 13. Supportive Services
612:10-7-130. Maintenance [AMENDED]
612:10-7-131. Transportation [AMENDED]
Part 15. Training
612:10-7-142. General guidelines for training services [AMENDED]
612:10-7-143. Coordination of training with other services [REVOKED]
612:10-7-145. Counseling activities during training program [AMENDED]
612:10-7-147. Special scholarships and training facilities [REVOKED]
612:10-7-150. Continued eligibility for college or university training [AMENDED]
612:10-7-151. Duration of college and university training [AMENDED]
612:10-7-152. Payment of tuition and fees at colleges and universities [AMENDED]
612:10-7-153. Textbook allowance for college and university students [AMENDED]
612:10-7-154. Allowance for durable training supplies for college and university students [REVOKED]
612:10-7-157. Out-of-state training [AMENDED]
612:10-7-159. Privately owned business and trade schools [AMENDED]
612:10-7-161. Public vocational schools [AMENDED]
612:10-7-162. Supplies and training tools for business, vocational and trade schools [AMENDED]
612:10-7-163. On-the-job training [AMENDED]
612:10-7-164. Personal and work adjustment training [AMENDED]
612:10-7-168. Duties of home counselor [REVOKED]
612:10-7-169. Duties of counselors who supervise clients in training facilities [REVOKED]
Part 21. Purchase of Equipment, Occupational Licenses and Certificates
612:10-7-220. Vehicle modification services [AMENDED]
Part 23. Self-employment Programs and Other Services
612:10-7-230. Self-employment programs [AMENDED]
612:10-7-230.1. Definitions [REVOKED]
612:10-7-230.2. Self-Employment Guidelines [AMENDED]
612:10-7-230.3. Self-Employment/Business Plans [AMENDED]
612:10-7-230.4. Agency financial contribution to self-employment/purchasing [AMENDED]
612:10-7-230.5. DRS Monitoring [AMENDED]
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Part 15. Training
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N/A
ANALYSIS:
Changes to Chapter 10 align policy with state law changing the authority order limit on purchasing; permits the agency to provide services to a larger group of low-income individuals; gives the professional counselor the power to make the decisions and be responsible for their decisions; clarifies that PELL and other federal/state student aid is applied as first dollar to the cost of college, university, vocational and trade school expenses before VR funds are used for this purpose; and aligns policy more closely with federal rules under the Rehabilitation Act, to improve clarity and remove extraneous language.
CONTACT PERSON:
Ray Leard, Administrative Programs Officer, Policy Development, Department of Rehabilitation Services, 3535 N.W. 58th, Suite 500, Oklahoma City, OK 73112 (405) 951-3406

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, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

612:10-1-7. Purchase of services and goods for individuals with disabilities

(a) All Department authorizations are made in compliance with the state purchasing policy under legal authority of the Director or by an employee to whom the Director has delegated such authority. Services, other than diagnosis, must be in an approved Individualized Plan for Employment prior to authorization. All authorizations are to be issued prior to or simultaneously with the provision of the services. Verbal authorizations may be made when needed to ensure effective delivery of services. Verbal authorization must be followed immediately by the actual authorization. Separate authorizations for each fiscal year are required when a planned service extends beyond a single fiscal year. Rehabilitation professionals may not authorize fees for services in excess of those established by the Department unless approved by the Division Administrator. A prior written purchasing agreement is required before authorization can be made to any medical vendor or post-secondary school. Other nonmedical vendors will not require a prior written purchasing agreement unless stated otherwise in the DRS policy manual section(s) for that service. When a vendor has a prior written purchasing agreement with the Department, and required approvals have been obtained, authorization may be issued for consumer services directly to that vendor. All other consumer services will be purchased pursuant to the rules in (g) and (h) of this Section. However, a requisition may be submitted to the DRS Purchasing Section if, in the judgment of the responsible rehabilitation professional, the best interests of the consumer and/or the agency would be served by having the Purchasing Section handle the procurement. In either case, once items have been received and checked against the authorization, the appropriate DVR or DVS staff, in accordance with (g) and (h) of this Section, ~~signs~~approves the claim, then forwards it to the DRS ~~Budget and Finance Unit~~ Financial Services Division. When a vendor does not abide by the authorization or written purchasing agreement or bills and accepts fees from the client in addition to those agreed upon, the rehabilitation professional will bring this to the immediate attention of the supervisor for action by the administration. The vendor will not be used for further rehabilitation services until agreement to discontinue the objectionable practice is reached.

(b) Since the Department is a state-federal agency, it does not pay sales, excise, or transportation taxes.

(c) All claims for medical and/or nonmedical client services must be filed on claim forms approved by the Department. When the provision of an authorization is fulfilled, payment for the authorized client services constitutes payment in full. The client will not have any financial liability other than the amount required of clients who must participate in the cost of the service provided. The individual is liable for services he/she arranged which were not planned and initiated under the auspices of DRS. When DVR and DVS funds are used to supplement third party medical resources, participation cannot exceed the difference between the third-party payment and the Department's established schedule.

(d) The client must transfer, assign, or authorize payments to the Department of any and all claims against Health Insurance or Liability Insurance companies or other third parties, to the full extent of all payments for medical services made by the Department.

(e) The Department retains right and title to any tools, equipment, durable medical equipment, or other goods costing $500 or more purchased with DVR and DVS funds, until and unless such goods are released to the client. Upon delivery of any such goods to the client, a Receipt for Equipment and Title Agreement must be completed and ~~signed~~approved.

(1) **Completion of Program:** Any tools, equipment or durable medical goods purchased for training or occupational purposes remain with the client after completion of the program of services if they can be used in the client's chosen vocation. If the client fails to complete the program of service, the counselor will make effort to reclaim the goods to transfer to another client.

(2) **Disposition at closure:** Case recording must reflect the disposition at the time of closure of tools, equipment, and goods provided the client. All occupational tools, equipment, and durable medical goods remain the property of the agency until released. If the client is not using the items, the counselor will pick them up if an economical savings to the agency will result, and if the transfer will not endanger the health or safety of the client.

(3) **Title Release:** Title on any tools, equipment or durable medical equipment purchased with DRS funds for training or occupational purposes will not be released to the client until the counselor has determined the client is rehabilitated and using the items as planned.

(f) When the rehabilitation professional determines an authorization or portion of an authorization will not be utilized, procedures to cancel the remaining services will be completed.

Before the case is closed, all unliquidated authorizations must be canceled or accounted for to determine if a claim will be made against any outstanding authorization.

(g) Purchasing consumer goods or services, other than direct client payments, when there is no prior written purchasing agreement is basically a three step process. These steps include specifying the requirements for the goods or services, authorizing for the purchase, and receiving delivery of the goods or services. For audit purposes, no one person can perform more than one of these steps. A different person is required for:

(1) identifying the requirement for the purchase;

(2) placing the order; and

(3) accepting the material or service.

(h) When a prior written purchasing agreement for consumer goods or services, other than direct client payments, is not required, and the service or package of services to be obtained will cost ~~$2500~~ the amount of the DCS authority order limit or less, the rehabilitation professional and client will jointly choose an appropriate vendor. The rehabilitation professional will then authorize for the planned services to the chosen vendor. When a prior written purchasing agreement for consumer services, other than direct client payments, is not required, and the service or package of services will cost more than ~~$2500~~ the DCS authority order limit, the rehabilitation professional will follow rules in (1) through (7) of this Subsection.

(1) The rehabilitation professional will obtain specialist recommendations for purchase requirements and approvals in accordance with agency policy.

(2) The participation of the client, or the client's authorized representative, will be obtained in deciding upon at least three vendors to be contacted by the rehabilitation professional to obtain bids for the goods or services. The rehabilitation professional will review available vendor information with the client, or client's authorized representative, to jointly determine which vendor(s) can best meet the needs of the client in terms of product and service function, quality, and vendor accessibility.

(3) At least three vendors offering the goods or services will be contacted to obtain bids. To expedite planning and service delivery, bids may be obtained verbally. Upon request, contacted vendors will be afforded at least 24 hours in which to prepare and submit the verbal bid. The rehabilitation professional will ensure that all bids are submitted in writing for the same or comparable items, and will document the bids received by using the Vendor Bid Documentation Form.

(4) The rehabilitation professional will issue the appropriate authorization and claim to the vendor submitting the lowest and best bid. If the rehabilitation professional managing the case is also the recognized specialist who identified the purchase requirements, then the supervisor will issue the appropriate authorization. Authorization may be issued to a vendor not submitting the lowest bid only with strong documentation that the selected vendor can best meet the needs of the client. When the bid is in excess of $10,000.00 the successful bidder will sign a non-collusion statement (to be sent with the claim), which will be maintained in the case service record.

(5) In the case of a vehicle modification or housing modification, upon completion of the authorized services, the counselor will contact the AT Specialist to schedule inspection of the work in accordance with 612:10-7-220 and 612:10-11-38. The AT Specialist will complete the "Assistive Technology Inspection Report" verifying the modification conforms to acceptable standards and the work is satisfactory.

(6) Upon delivery of the goods or services in accordance with the IPE and authorization, a rehabilitation staff person other than the specialist who specified the purchase requirements and the rehabilitation professional who authorized the purchase will accept delivery, verify that goods received match the vendor invoice, sign the appropriate claim form, sign and attach the invoice and forward them to the DRS ~~Budget and Finance Unit~~ Financial Services Division.

(7) Upon delivery of any goods costing $500 or more to the client, a Receipt for Equipment and Title Agreement must be completed and ~~signed~~ approved.

(8) Itemized documentation will be in the case record on all orders costing less than $500 and the client will acknowledge their receipt. (For example, signing and dating the packaging slip, vendor's invoice, or typed list of goods.)

(9) Returned or repossessed items must be documented on for "Receipt for Equipment and Title Agreement" and the final disposition noted in Case Narrative entry.

(i) Program Managers will review case records when submitted for approvals to ensure that purchases are being awarded in a manner that ensures competition and client participation within the scope of DRS and applicable fiscal rules. At least once each fiscal year a random selection of case records will be reviewed by the DRS Central/Departmental Services Unit to monitor compliance with DRS and applicable fiscal rules. If a Program Manager has reason to believe that a rehabilitation professional is not making a good faith effort to award purchases in a competitive manner and in accordance with agency policy, a fiscal audit of the entire caseload will be requested to determine the appropriate action to take.

(j) Pursuant to 74 O.S. 85.44A, any goods or services required under a court order shall be purchased in accordance with DRS fiscal rules.

612:10-1-10. CARF - Vendors

Each Employment vendor who is required contractually by the Department of Rehabilitation Services to be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) will achieve at least a successful accreditation outcome by June 30, 2011.

SUBCHAPTER 3. CLIENT PARTICIPATION IN COST OF SERVICES

612:10-3-5. Basic living requirements

(a) A basic living requirement has been established for different size family groups. A family member is an individual who ~~either (A)~~ is a relative or guardian of an applicant or eligible individual~~; or (B) Lives in the same household as an applicant or eligible individual and has a substantial interest in the well-being of that individual and whose receipt of vocational rehabilitation services is necessary to enable the applicant or eligible individual to achieve an employment outcome~~. Basic living requirements are based on ~~150%~~200% of the Federal poverty level adjusted annually for family size. The standard is intended to cover only the necessities of food, shelter, utilities, clothing, transportation, and incidentals to give the counselor some criteria by which to measure the financial status of a client. To qualify as independent from the family group, the client must meet one of the following criteria:

(1) Beneficiary of Titles II (federal old age, survivors, and disability insurance benefits) or XVI (SSI);

(2) At least 24 years of age;

(3) A ward of the court and in custody of DHS;

(4) Married and maintaining a separate household;

(5) Meets the criteria for temporary housing as described in 612:10-3-5(c) or;

(6) The counselor verifies the client has the financial resources to demonstrate self-sufficiency and the client declares no family contributions are available.

(b) Verification of family membership should be based upon whatever available information most accurately documents family membership according to the definition given in this Subsection. Examples of acceptable verification include the latest Federal income tax return, payroll information, insurance policies, client report, and/or counselor observation.

(c) An eligible ~~adult~~ individual whose disability has resulted in the need to live with family or friends~~temporarily~~, and as appropriate the individual's spouse and dependent children, will be considered as a separate household regardless of living arrangements.

SUBCHAPTER 7. VOCATIONAL REHABILITATION AND VISUAL SERVICES

PART 1. SCOPE OF VOCATIONAL REHABILITATION AND VISUAL SERVICES

612:10-7-1. Overview of Vocational Rehabilitation and Visual Services

(a) ~~This Subchapter discusses services within the scope of the Vocational Rehabilitation and Visual Services programs. Generally, these services are referred to as vocational rehabilitation services or VR services.~~ Vocational rehabilitation services are provided by the Division of Vocational Rehabilitation and the Division of Visual Services~~. Vocational rehabilitation services are provided~~ to help eligible individuals achieve employment outcomes that are consistent with the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of each eligible individual. To the maximum extent appropriate, VR services are meant to result in competitive employment in an integrated setting. Vocational rehabilitation services include services for individuals and services to groups of individuals.

(b) Vocational rehabilitation services for individuals include:

(1) an assessment for determining eligibility and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology;

(2) counseling and guidance, including information and support services to assist an individual in exercising informed choice;

(3) referral and other services to secure needed services from other agencies through cooperative agreements if such services are not available from DVR or DVS;

(4) job-related services, including job search and placement assistance, job retention services, ongoing services, and extended services;

(5) vocational and other training services, including the provision of personal and vocational adjustment services, books, tools, and other training materials, except that no training services provided at an institution of higher education shall be paid for with funds under this title unless maximum efforts have been made by DVR or DVS staff and the individual to secure grant assistance, in whole or in part, from other sources to pay for such training;

(6) to the extent that financial support is not readily available from a source (such as through health insurance of the individual or through comparable services and benefits) other than DVR or DVS, diagnosis and treatment of physical and mental impairments, including:

(A) corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical or mental condition that constitutes a substantial impediment to employment, but is of such a nature that such correction or modification may reasonably be expected to eliminate or reduce such impediment to employment within a reasonable length of time;

(B) necessary hospitalization in connection with surgery or treatment;

(C) prosthetic and orthotic devices;

(D) eyeglasses and visual services as prescribed by qualified personnel who meet State licensure laws and who are selected by the individual;

(E) special services (including transplantation and dialysis), artificial kidneys, and supplies necessary for the treatment of individuals with end-stage renal disease; and

(F) diagnosis and treatment for mental and emotional disorders by qualified personnel who meet State licensure laws;

(7) maintenance for additional costs incurred while participating in an assessment for determining eligibility and vocational rehabilitation needs or while receiving services under an Individualized Plan for Employment;

(8) transportation, including adequate training in the use of public transportation vehicles and systems, that is

provided in connection with the provision of any other service described in this section and needed by the individual to achieve an employment outcome;

(9) on-the-job or other related personal assistance services provided while an individual is receiving other services described in this section;

(10) interpreter services provided by qualified personnel for individuals who are deaf or hard of hearing, and reader services for individuals who are determined to be blind, after an examination by qualified personnel who meet State licensure laws;

(11) rehabilitation teaching services, and orientation and mobility services, for individuals who are blind;

(12) occupational licenses, tools, equipment, and initial stocks and supplies;

(13) technical assistance and other consultation services to conduct market analyses, develop business plans, and otherwise provide resources, to the extent such resources are authorized to be provided through the statewide workforce investment system, to eligible individuals who are pursuing self-employment or telecommuting or establishing a small business operation as an employment outcome;

(14) rehabilitation technology, including telecommunications, sensory, and other technological aids and devices;

(15) transition services for students with disabilities, that facilitate the achievement of the employment outcome identified in the Individualized Plan for Employment;

(16) supported employment services for individuals with the most significant disabilities that need ongoing support services from a job coach to obtain and maintain employment;

(17) employment and retention services for individuals with significant disabilities who require short term job coach support to obtain and maintain a successful employment outcome;

(18) transitional employment services for individuals with the most significant disabilities due to mental illness who have little or no successful work history and need work adjustment/trial work experience;

(19) job placement services for individuals with disabilities who are job ready;

(20) services to the family of an individual with a disability necessary to assist the individual to achieve an employment outcome; and

(21) specific post-employment services necessary to assist an individual with a disability to, retain, regain, or advance in employment.

(c) Vocational rehabilitation services for groups of individuals include:

(1) in the case of any type of small business operated by individuals with significant disabilities the operation of which can be improved by management services and supervision provided by DVR or DVS, the provision of such services and supervision, along or together with the acquisition by DVR or DVS of vending facilities or other equipment and initial stocks and supplies;

(2) services that contribute to the rehabilitation of a group of individuals not related to an IPE, including:

(A) the establishment, development, or improvement of community rehabilitation programs, including, under special circumstances, the construction of a facility. Such programs shall be used to provide services that promote integration and competitive employment; and

(B) the provision of other services, that promise to contribute substantially to the rehabilitation of a group of individuals but that are not related directly to the individualized plan for employment of any one individual with a disability;

(3) the use of telecommunications systems (including telephone, television, satellite, radio, and other similar systems) that have the potential for substantially improving delivery methods of activities described in this section and developing appropriate programming to meet the particular needs of individuals with disabilities;

(4) special services to provide nonvisual access to information for individuals who are blind, including:

(A) the use of telecommunications, Braille, sound recordings, or other appropriate media;

(B) captioned television, films, or video cassettes for individuals who are deaf or hard of hearing;

(C) tactile materials for individuals who are deaf-blind; and

(D) other special services that provide information through tactile, vibratory, auditory, and visual media.

(5) technical assistance and support services to businesses that are not subject to Title I of the Americans with Disabilities Act of 1990 [42 USC 12111 et seq.] and that are seeking to employ individuals with disabilities; and

(6) consultative and technical assistance services to assist educational agencies in planning for the transition of students with disabilities from school to post-school activities, including employment.

612:10-7-2. Field ~~Office~~staff responsibilities

(a) The counselor is responsible for contacting each referral within 30 days of receipt of the referral information. The counselor is responsible for completing a contact by telephone or in person. The counselor is responsible for providing interpreter services to applicants who are deaf or non-English speaking.

(b) The rehabilitation counselor is responsible for the determination of an individual's eligibility to receive services from DVR or DVS. ~~Individuals who are legally blind are to be referred to the appropriate rehabilitation teacher for determination of eligibility for the rehabilitation teaching program.~~ In cases where the counselor has difficulty in making an eligibility determination, the counselor will consult with the supervisor. For further clarification, the case will be reviewed by the field coordinator for a decision. ~~All cases referred must be accompanied by all available medical information and sufficient social and vocational information. The rehabilitation teacher is responsible for the determination of an individual's eligibility to receive services from the Rehabilitation Teaching Program. The counselor will apply eligibility criteria to all applicants in an equitable manner, without regard to race, age, sex, color, creed, national origin or disability type~~ Individuals

who are legally blind are to be referred to the appropriate rehabilitation teacher for determination of eligibility for the rehabilitation teaching program.

(c) The ~~counselor~~ counselor's ~~always considers the~~ primary ~~and basic~~ vocational rehabilitation service ~~as~~is counseling and guidance with job placement. ~~Any service beyond this~~Additional services must be justified as necessary to compensate for, correct or circumvent an impediment to employment. Every IPE must include a plan of counseling and guidance services. Regular documentation of counseling sessions will be included in every DVR and DVS case.

(d) The rehabilitation counselor is to ensure that the client is a full participant in the decisions that are made concerning his or her vocational rehabilitation. This responsibility is carried out by providing the individual with as much relevant information as is available so that the individual, and/or the individual's authorized representative, can exercise informed choice consistent with the Department's policies. The minimum information concerning service choice to be supplied includes:

(1) service cost;

(2) available service providers;

(3) service accessibility;

(4) expected duration of services;

(5) consumer satisfaction with the services in question, to the extent that such information is available;

(6) qualifications of potential service providers;

(7) the types of services offered by the potential service providers;

(8) the degree to which services are provided in integrated settings; and

(9) outcomes achieved by individuals working with the service provider, to the extent such information is available.

(e) The individual will be notified in writing of any adverse determination made by professional staff concerning that individual's case. This notification will be made in a timely manner, and in a manner that supports the individual's right to due process.

(f) The counselor will complete a financial status determination form prior to the provision of any service (other than exempt services listed in 612:10-3-4) to determine if the client will be required to participate in the cost of services.

~~(g) A non-diagnostic service authorization will not be issued until after the service has been included in the IPE or in a plan for extended evaluation or trial work experience.~~

~~(h) All Department authorizations are made in compliance with the state purchasing policy under legal authority of the Director or by an employee to whom the Director has delegated such authority. The counselor will verify the client has received any tools, equipment, or durable medical goods purchased with DVR and DVS funds and, when appropriate, complete the Receipt for Equipment and Title Agreement.~~

(~~i~~g) The counselor will inform each individual of his or her rights and responsibilities as an applicant or client of DVR and DVS. Cross reference 612:10-7-~~150~~3

(~~j~~h) The Department of Rehabilitation Services (DRS) has an obligation under state and federal law to provide services in a fair and impartial manner. State Ethics Commission Rules state that the proper operation of state government requires that the state employee be independent and impartial; that state employees not use state office to obtain private benefits; that a state employee must avoid action which creates the appearance of using state office to obtain a private or inappropriate benefit; and that state employees exercise their powers without prejudice or favoritism.

(~~k~~i) The counselor is limited in determining eligibility for services for friends or relatives. At the time of application or referral, if in the counselor's judgment, the individual is familiar to the point of friendship, the counselor must immediately disclose this relationship to their supervisor in writing and obtain approval before determining eligibility. If the applicant is related by blood or marriage, the counselor must immediately refer the case to another counselor, if available. If no other counselor is available, the counselor must notify their supervisor immediately for appropriate case assignment. The counselor should also disclose the potential conflict of interest to the applicant and explain the reason for the potential delay of eligibility determination. The counselor must not only be impartial in the determination of eligibility but also act so that there can be no question of impartiality. The technician must also disclose to the counselor any relationship with the applicant that might create a conflict of interest. The counselor will then contact the Program Manager to see if the case can be worked without partiality or transferred to another counselor.

~~(l) The counselor will assess the stability of an individual's disability throughout the case to evaluate their ability to achieve their vocational objective and successfully achieve an employment outcome. If the goal is determined to be no longer realistic, the counselor must re-evaluate the IPE in order to make necessary and appropriate changes with the client. Provision of services must be aimed at removing, substantially modifying or compensating for restrictions, limitations, or impediments.~~

612:10-7-3. Client responsibilities

To make the rehabilitation effort a success, the individual and agency's staff must work together to reach chosen goals. This shared responsibility requires that the client or applicant for services accept the basic responsibilities in (1) through ~~(11)~~(12) of this Subsection. Other specific client responsibilities are stated in relevant manual sections. It is the counselor's responsibility to fully and appropriately inform the client of client responsibilities.

(1) Provide information and be available to complete the assessment process to find out if you are eligible for services.

(~~1~~2) ~~Keep appointments for medical examinations and other evaluations~~ Be on time and keep appointments with DVR/DVS staff, doctors and others. Call in advance or as soon as possible, if you cannot come to an appointment.

(~~2~~3) Follow the advice of doctors and other ~~licensed treatment~~ medical professionals.

(~~3~~4) ~~Take an active part~~ Participate with your DVR/DVS counselor in developing the Individualized Plan for Employment, (IPE) including participating in assessments needed to determine your needs and strengths.

(~~4~~5) Provide enrollment documents to home/supervisor counselor before the college or university's designated "Drop and Add" deadline so an authorization can be issued, if your IPE includes educational and training services.

(~~5~~6) Attend education or training classes on a regular basis and make at least passing grades, if your IPE includes these services.

(~~6~~7) ~~Take part in regular reviews (~~Review your IPE with your counselor at least once a year~~) of the Individualized Plan for Employment;~~ and ~~also take part~~participate in ~~any~~making revisions to the ~~program~~ plan when needed.

(~~7~~8) Maintain satisfactory progress toward completing the IPE.

(~~8~~9) ~~Must abstain~~Abstain from abuse of drugs and/or alcohol. Individuals who abuse drugs and/or alcohol while receiving services will be referred to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and/or other appropriate agencies for purposes of seeking treatment. All case services will be suspended. If the client refuses or fails to cooperate with seeking treatment, or is not available to pursue a DRS program, this will be considered as reasonable cause for case closure.

(~~9~~10) Keep the appropriate professional informed of changes in the individual's address, financial status, or other program-related changes.

(~~10~~11) Apply for and make appropriate use of any comparable benefits and services for which the client is eligible to defray in whole or in part the cost of services in the individual's IPE and provide verification of financial aid award status to counselor.

(~~11~~12) ~~Working~~Work with the counselor to obtain or keep suitable gainful employment or appropriate independent living outcomes as services are being completed.

612:10-7-6. Assessment for determining eligibility

(a) To determine whether an individual is eligible for vocational rehabilitation services :

(1) the counselor will use to the maximum extent possible and appropriate existing information that is current as of the date of the determination of eligibility or of the development of the IPE (for the purposes of this Section, current means that there has been no appreciable change in the individual's condition as described in the obtained documentation); and

(2) to the extent necessary provide appropriate assessments, including provision of goods and services during the assessment, to obtain additional documentation necessary to make the determination of eligibility and priority group assignment. The counselor will carefully evaluate the need to provide assistive technology devices and services or worksite assessments.

(b) The counselor will determine whether an individual is eligible for vocational rehabilitation services within a reasonable period of time, not to exceed 60 days after the individual has submitted an application for services. This time period may be extended only when unforeseen and exceptional circumstances beyond the control of the Department preclude completing the determination of eligibility within the 60 days and the individual agrees a specific extension of time is warranted as documented on the Need for Extension of Time to Determine Eligibility form; or a trial work period or an extended evaluation is needed to determine the individual's ability to benefit from VR services.

(c) The counselor must carefully assess the usefulness of any records obtained based upon the nature of the disability; the relevance and completeness of information contained in the records; and the nature and outcome of treatment, or other services, received by the client.

(d) Documentation that the individual has a disability which constitutes or results in an impediment to employment must come from professionals qualified in accordance with State law to diagnose the reported disability, except as provided in 612:10-7-4(b).

(e) Diagnosis and evaluation are to be provided only for determination of eligibility for VR services, priority group placement, and determination of VR service needs. DVR and DVS funds are not to be used to assist an individual in establishing eligibility for other programs.

(f) When necessary, diagnostic evaluations may be purchased at any time during the life of the case. ~~Diagnostic procedures that require hospitalization must be approved by the program manager.~~

(g) If an individual is determined eligible, the VR counselor will notify the individual in writing. If the individual is determined to be ineligible, counselor will close the case.

(h) A qualified rehabilitation professional can proceed with an assessment of eligibility if there is an obvious and/or observable disability. An interim decision based on an observable disability must be followed up with medical records.

PART 3. CASE PROCESSING REQUIREMENTS

612:10-7-27. Career planning center services [REVOKED]

~~(a) To evaluate the likely employment outcome of vocational rehabilitation services for an individual, the counselor needs to collect information regarding work history, special aptitudes, past training, and job expectations of the client. The purpose of career planning centers is to provide a systematic individualized program to assess the likely benefit of vocational rehabilitation services to the individual in terms of an employment outcome.~~

~~(b) Requests for vocational evaluations from outside agencies will be referred to the appropriate career planning center. The career planning center staff will inform the referring agency about referral procedures and daily charges. Outside agencies will be informed that DRS clients and persons with disabilities are given priority.~~

612:10-7-28. Vocational evaluation referrals [REVOKED]

~~All referrals for vocational evaluation will be processed in a uniform manner. If sufficient evaluative case information is available, vocational evaluation may not be necessary. The factors listed in (1) through (9) of this Subsection are to be considered in referring clients for vocational evaluation:~~

~~(1) The client has no previous work history.~~

~~(2) The client is unable to continue previous types of work due to onset of disability.~~

~~(3) The client needs occupational information and vocational counseling.~~

~~(4) The client has unrealistic vocational goals.~~

~~(5) The client needs job-site adaptations and modifications.~~

~~(6) The client's physical and mental capabilities and limitations need to be assessed.~~

~~(7) The client's previous or current vocational services have been unsuccessful or inappropriate.~~

~~(8) The client's work skills or work tolerances are undetermined.~~

~~(9) When general observations are needed; i.e., behavior, work habits, motivation, social.~~

612:10-7-29. Vocational evaluation referral process [REVOKED]

~~(a) **Information.** Forms and information needed to make a referral are:~~

~~(1) Special Services Referral Form;~~

~~(2) Application;~~

~~(3) Initial Interview Narrative Recording;~~

~~(4) Pertinent case narratives;~~

~~(5) Specialist's reports; i.e., orthopedic, speech, visual;~~

~~(6) Psychological information is required if a mental or emotional disability is alleged;~~

~~(7) Other appropriate information; i.e., transcripts, records of previous testing, etc.~~

~~(b) **Scheduling.**~~

~~(1) Upon receipt of referral information, the individual and referring counselor will be notified.~~

~~(2) An appointment letter will be sent to the individual and referring counselor approximately two weeks prior to scheduled appointment date.~~

~~(3) Individuals in need of special scheduling arrangements will be accommodated upon request by referring counselor.~~

612:10-7-30. Supportive services at career planning centers [REVOKED]

~~(a) Referring counselors are responsible for arranging support services the client may need while in evaluation; i.e., personal care attendant (PCA), interpreter, etc.; and for notifying the center of these arrangements.~~

~~(b) Career planning centers will be responsible for arranging motel accommodations, taxi service, and meals at the request of the referring counselor. Centers will issue authorizations for these services.~~

612:10-7-32. Production standards [REVOKED]

~~(a) It is every staff person's responsibility to ensure the provision of quality services in a timely manner to individuals with disabilities with impediments to employment. The counselor, by good caseload management, can provide quality services and meet reasonable production standards.~~

~~(b) The size of a caseload and the standards for production vary according to such factors as the type of territory served, density of population, type of disability groups served, etc.~~

~~(c) Production statistics are regularly reviewed to determine individual training needs to assist the counselor in maximizing services to clients.~~

612:10-7-33. Supervisory caseload reviews [REVOKED]

~~(a) Each programs manager reviews a sample of active cases each production year. The purpose of these reviews is to monitor and contribute to the improvement of the quality of work being done on each caseload in accordance with Departmental policy, RSA regulations and ethical standards.~~

~~(b) The appropriate review form will be completed for each case reviewed in accordance with instructions. Each programs manager is responsible for setting a schedule of case reviews in his or her area. The results of the reviews for each caseload are to be used in evaluating performance of each vocational rehabilitation specialist and rehabilitation technician and as a basis for further performance development plan.~~

612:10-7-33.1. Quality Assurance caseload reviews [REVOKED]

~~(a) The Quality Assurance Unit will conduct statewide audits of closed cases. The purpose of these audits is to ensure uniform application of agency policies and to identify areas for which in-service training may be needed.~~

~~(b) The Programs Manager may request the quality Assurance Unit to assist them with audits on active cases.~~

PART 5. CASE STATUS AND CLASSIFICATION SYSTEM

612:10-7-47. Application Status

(a) **Application for services.** An individual is considered to have submitted an application when the individual, or the individual's authorized representative, as appropriate:

(1) has completed and signed an application form or has otherwise requested services (includes, but is not limited to requests made verbally, by telephone, in writing, by facsimile, etc.);

(2) has submitted the application form, or other documentation meeting the requirements of paragraphs (a) & (b), to the receiving office where it will be date-stamped;

(3) has provided information necessary to initiate an assessment to determine eligibility and priority for services; and

(4) is available to complete the assessment process.

(b) **Necessary information.** The minimum information necessary to initiate an assessment to determine eligibility and priority for services consists of:

(1) individual's name;

(2) reported disability;

(3) individual's address, with finding directions when needed;

(4) individual's social security number, if available; and

(5) availability of documentation of the reported disability.

(c) **Application Status.** While the client is in this status, the counselor will secure sufficient information to make a determination of eligibility and priority group assignment, determine ineligibility for vocational rehabilitation services, or to make a decision to conduct a Trial Work Experience or an Extended Evaluation. The VR Professional will determine whether an individual is eligible for vocational rehabilitation services within a reasonable period of time, not to exceed 60 days from the date of application. [612:10-7-6]

(d) **Case recording requirements - initial interview.** ~~One of the significant steps in the case process is recording the initial interview.~~ Pertinent information from the initial interview and applicant information forms is recorded ~~on the client information sheet and~~ in a narrative ~~recording~~ that is placed in the case file. ~~This assists the counselor in summarizing the significant information known about the client.~~ The ~~client information sheet~~ narrative will indicate the available background information such as social, vocational, psychological, medical and educational data; as well as the basis for application. The narrative recording includes factors affecting the individual's rehabilitation needs and goals, counselor's impressions, and counselor/teacher and client plans. The counselor will address such significant factors as client's appearance, social skills, attitudes, communication skills, etc. Counselor will also include any impressions concerning potential eligibility and other significant environmental factors that may have impact on the planning and provision of ~~services.~~ service and ~~Outline~~ outline the next steps to be taken in the vocational rehabilitation process, including time frames and specific responsibilities.

(1) The record must document that the applicant or representative was provided an explanation of his/her rights and responsibilities and given a copy of the CAP brochure and ~~a "A Personal Directory: Your Rights and Responsibilities as an Applicant or Client for Vocational Rehabilitation or Visual Services."~~approved client handbook.

(2) ~~The counselor's perceptions are extremely important during the initial interview since most of the information, attitudes, and impressions gathered during the initial interview will have a major impact on the rehabilitation process~~ The record must document that the applicant was given the opportunity to register to vote or change registration when applying for or receiving services, in accordance with the requirements of the National Voter Registration Act of 1993.

612:10-7-49. Closed - Not Accepted for Services

(a) **Not accepted for services.** This status is used for closing cases in which the individual is not accepted for vocational rehabilitation services, whether closed from applicant status or from ~~an extended evaluation or a~~ trial work experience or extended evaluation status. There are two major categories of closure:

(1) **Closure due to ineligibility.**

(A) Disability too severe (from Trial Work Experience or Extended Evaluation only) or unfavorable medical prognosis.

(B) No disabling condition.

(C) No impediment to employment.

(D) Rehabilitation services are not required for an employment outcome.

(2) **Closure due to other reasons.**

(A) Unable to locate.

(B) Moved out of state.

(C) Refused services or further services.

(D) Death.

(E) Client institutionalized.

(F) Transfer to another agency.

(G) Failure to cooperate.

(H) Transportation not feasible or available.

(I) Client did not meet order of selection criteria.

(J) Other reasons.

(b) **Personal contacts.** Personal contacts are made with all persons closed in this status, if possible, and the results of those contacts are recorded in a case narrative. If the applicant cannot be contacted, all attempts to contact are recorded. Contacts are not required if the individual has refused to participate, is no longer a resident of Oklahoma, whereabouts are unknown, or the condition is rapidly progressive or terminal.

(c) **Case recording requirements.** All applicants whose cases are closed in this status should be notified in writing, with the exceptions noted in ~~sub-paragarph~~ sub-paragraph (b). A case is closed due to ineligibility only with full participation of the applicant, the applicant's parent, guardian, or other representative unless the individual has refused to participate, is no longer a resident of Oklahoma, whereabouts are unknown, or the condition is rapidly progressive or terminal. The rationale for the ineligibility decision is recorded on the closure letter including the views of the applicant or appropriate representative. A copy of the letter is given to the applicant or appropriate representative with a detailed explanation of the services available from the Client Assistance Program no matter the reason for closure. It is presumed an individual can benefit from rehabilitation services in terms of an employment outcome. Evidence to the contrary can only be obtained through trial work experience or extended evaluation. Procedures for annual review of ineligibility are to be explained to the applicant or appropriate representative in an understandable form.

612:10-7-62. Post-Employment services

(a) **Use of Post-Employment services.** Post-employment services may be provided to assist rehabilitated clients to retain, regain, or advance in employment, consistent with the individual's strengths, resources, priorities, concerns,

abilities, capabilities, interests and informed choice. ~~Planning for and provision of post-employment services is one of the more important elements of the agency's service.~~ The need for post-employment services will be assessed at initiation of the IPE. Ongoing assessment continues during case services, is documented as needed, and is reassessed just prior to case closure. Post-employment services may also be provided for needs that were not anticipated in the original IPE or prior to case closure. ~~Counseling and guidance is the primary service around which all other post-employment services are provided.~~ Post employment services can be provided to individuals who receive Supported Employment Services if such services are needed to maintain the supported employment placement and those services are not available from an extended services provider. ~~Some examples of post employment services are maintenance of assistive technology, job station redesign, and replacement of prosthetic and orthotic devices.~~ Post employment services are not to be used in instances of underemployment when extensive retraining is needed. Cases reopened on a post-employment basis do not require re-establishment of eligibility. New diagnosis is needed only if there has been a change in the client's physical or mental condition. Any vocational rehabilitation service or combination of services necessary to assist the individual retain, regain, or advance in employment may be provided if the service(s) does not involve a complex or comprehensive effort. If comprehensive services are indicated, a new application is taken. Federal regulations forbid the setting of arbitrary time limits on the provision of post-employment services. If the client has been employed for a long period of time, the counselor must carefully review the client's situation before making the decision to provide post-employment services as opposed to opening a new case.

(b) **Other considerations.** Other considerations in determining a client's eligibility for post-employment services are:

(1) **Financial Status.** A new financial status determination must be made if services requiring consideration of client participation in the cost of services are to be provided.

(2) **Emergency conditions.** Treatment of an emergency condition will not be considered as a post-employment service.

(3) **Upgrading.** Post-employment services are provided to help the individual advance in employment only when the nature of the individual's impediment to employment makes advancement the most appropriate post-employment outcome consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

(c) **Transfer of cases.** Clients needing post-employment services who have moved to another area of the state will have their cases transferred. When a rehabilitant who has moved out of state requests post-employment services, the counselor will refer the individual to the rehabilitation program in the state where the individual resides. Upon receipt of a release signed by the client, copies of the requested information from the closed case record will be forwarded to the receiving state agency. If an individual who was a rehabilitant in another state requests post-employment services from our state, information must be requested from the state where services were previously provided. All requests must include a specific release of confidential information signed by the applicant. The case will be processed as a new referral, but will be served and documented as a post-employment case.

(d) **Criteria for terminating post-employment services.** Decisions to terminate post-employment services must be made on an individual basis in consultation with the client and will be recorded in the case. The counselor will need to work with the individual to achieve a satisfactory level of self sufficiency independent of post-employment support.

(e) **Case recording requirements.** Post-employment services is the same as any other service status. The same principles of client involvement are required in the IPE for Post-Employment Services as are required under any other IPE. Case recording will be made at significant times during the process, including assessment of progress, and the results achieved at the completion or termination of services.

PART 9. ACTIONS REQUIRING REVIEW AND APPROVAL

612:10-7-87. Actions requiring supervisor's approval

The supervisor indicates approval by signing the appropriate documentation or form in the case, or by memorandum when necessary. Verbal approval may be given when circumstances warrant, but must be followed immediately by written approval. The supervisor may delegate approval authority for designated duties to a Specialist IV. The Specialist IV may assume responsibilities for approval when absolutely necessary because of prolonged absence of the supervisor or similar reasons, and when arrangements cannot be made for another supervisor to perform duties for the absent supervisor. The appropriate field coordinator's approval must be obtained for any such substitution or delegation.

(1) All actions of a newly employed counselor/teacher. The newly employed counselor/teacher will remain under intensive supervision until the counselor/teacher has reached a sufficient level of competence to work under general supervision as documented by the program manager. The release from intensive supervision will be given to the counselor/teacher in writing with a copy to the field coordinator. A counselor or teacher can be returned to intensive supervision when documentation or observation indicates he or she is no longer at a level of competence to work under general supervision. This decision will be given to the counselor/teacher in writing with a copy to the field coordinator.

(2) All IPE's or amendments when the total of the planned DVR and DVS expenditures for the entire case exceed ~~$15,000~~$25,000.

~~(3) Purchase of hospitalization for diagnostic purposes.~~

~~(4) Release of confidential information in instances not covered in 612:10-1-5.~~

(~~5~~3) All case closures in which an IPE was developed and services initiated.

(~~6~~4) Transfer of cases from one counselor/teacher caseload to another outside the sending supervisor's unit (signed by the supervisor of the sending counselor or teacher).

(~~7~~5) All IPE's which include purchase of physical or mental restoration services, prescription drugs or prescribed medical supplies lasting more than three months.

~~(8) Maintenance for job search services beyond 1 (one) month. (Specialist IV may approve)~~

~~(9) Clothing expenses in excess of $400.00 (Specialist IV may approve)~~

(~~10~~6) Small Business plan in excess of $10,000.00.

(7) Vehicle or home modifications over the DCS authority order limit.

612:10-7-88. Actions requiring field coordinator's approval [REVOKED]

~~Field coordinator approval is requested by written memorandum from the counselor, accompanied by a written recommendation from the supervisor. The field coordinator gives his or her approval in a written memorandum to the counselor, with a copy going to the supervisor. Verbal approval may be given when circumstances warrant, but must be followed immediately by written approval. The field coordinator must approve:~~

~~(1) all IPE's which include DVR and DVS funding of training beyond the bachelor's degree level;~~

~~(2) delegation or substitution for supervisory approval in case of supervisor's prolonged absence or similar circumstances.~~

~~(3) dental services during active job search.~~

~~(4) dental services requiring hospitalization.~~

~~(5) self-employment funding over $15,000.00.~~

~~(6) vehicle or home modifications over $2,500.00.~~

~~(7) purchase of Cochlear implants.~~

~~(8) Individual Plans for Employment that include vehicle repairs exceeding $1,000.00 for the life of the case.~~

PART 11. PHYSICAL AND MENTAL RESTORATION SERVICES

612:10-7-98. General guidelines for physical and mental restoration services

(a) To the extent that assistance is not readily available from a source other than DVR or DVS, diagnosis and treatment of physical and mental impairments may be provided to contribute directly to the individual's employment outcome. This can be either job retention or job placement. Physical or mental restoration services are provided only when the condition is stable, or slowly progressive. A slowly progressive condition is one in which the client's functional capacity is not expected to diminish so rapidly as to prevent successful completion of vocational rehabilitation services, and/or employment for a reasonable period of time. The individual is liable for services he or she arranged which were not planned and initiated under the auspices of DVR and DVS. DVR and DVS will not pay for hospitalization or treatment occurring prior to initiation of an IPE. DVR and DVS will not pay for emergency hospitalization or treatment needed at the time of referral. However, diagnostic examinations or information may be paid from DVR and DVS funds for use in eligibility determination, priority group placement, or determination of vocational rehabilitation needs. Physical and/or mental restoration services will be purchased only from licensed or board certified health professionals. Payment will be made in accordance with the established fee schedule of the Department.

(b) Temporary conditions with sudden onset do not fall within the definition of impairment for eligibility purposes. Emergency treatment of remediable conditions will not be purchased by DVR and DVS except under intercurrent illness policy. When the staff is in doubt as to the effect of such a condition upon the outcome of the IPE objectives, a medical consultation may be requested.

(c) Some individuals have stable or slowly progressive conditions of long duration. These conditions affect the client's ability to remain in or enter remunerative competitive employment and cannot be expected to heal without medical intervention. DVR and DVS do not provide long-term or ongoing physical or psychological treatment. DVR and DVS funds cannot be used to initiate treatment that is reasonably anticipated to last more than three months unless supervisory approval has been obtained for a three month extension. Additional three month extensions may be approved only if client maintains reasonable progress toward achieving the vocational goal. Persons needing long-term or ongoing treatment are to be referred to ~~the Department of Human Services' Medical Assistance Program~~ other medical assistance sources if available. DVR and DVS funds may be used to pay the costs for treatment of stable, or at worst, slowly progressive conditions when the conditions in (1) and (2) of this Subsection are met.

(1) The individual's employment is endangered or the client has lost employment due to the condition requiring treatment.

(2) Payment from DVR and DVS funds may be planned and authorized only after applicable third party pay sources provide verification of the expense they will cover, and not cover, associated with the physical or mental restoration services in question. When DVR and DVS funds are used to supplement a third party pay source, planned services and the authorization will be limited to those expenses that fall within the scope of the program and that do not exceed the difference between what the third party pay source will pay and the Department's established payment schedule.

(d) Individuals with chronic disabilities that can be removed with little or no residual limitations will not be eligible for purchase of services other than those related to the required treatment.

612:10-7-101. Convalescent care [REVOKED]

~~(a) Convalescent care may be provided, not to exceed 90 days, in an approved convalescent facility or nursing home following provision of physical restoration if recommended by~~

~~the physician. This service will be provided only if such services cannot be obtained from another source. Convalescent care will not exceed 90 days during the life of the case.~~
~~(b) The provision of this service requires Supervisory Approval.~~

612:10-7-102. Dental services

(a) If the counselor determines the client has a dental condition that poses a substantial impediment to job search or retention, dental services may be provided with Field Coordinator approval. Dental services provided concurrently during the provision of other services must meet the requirements for intercurrent illness (612:10-7-107)~~ and do not require Field Coordinator approval~~.
(b) Dental services may be provided only by licensed dentists who have current medical vendor agreements with the Department of Rehabilitation Services. Hospitalization for such treatment is done only when there is the presence of a medical condition requiring hospitalization.~~ Field Coordinator approval is required.~~

612:10-7-103. Dialysis or treatment of end-stage renal disease

~~(a)~~ DVR and DVS may assist with the cost of Medicare deductible, co-insurance, and services not covered by Medicare if documentation states other resources are not available and the client is actively participating in an IPE with treatment as part of the plan. Long term treatment of end-stage renal disease is not within the scope of the medical services program. Requests for kidney transplants must be approved by the medical consultant.
~~(b) Treatment may be authorized in three month increments with supervisory approval only if the client continues to make satisfactory progress toward the vocational objective.~~

612:10-7-104. Drugs and supplies

(a) Prescription drugs and/or prescribed medical supplies may be purchased when required for proper diagnosis, for post-operative treatment, or to stabilize a documented disability. The need for the drugs and/or medical supplies must be documented in a physician's report. Prescription drugs and/or prescribed medical supplies which are part of a treatment plan are not to be purchased unless they are necessary to achieve an ~~intermediate~~ employment objective established in the IPE. The counselor can plan the purchase of prescribed drugs and/or medical supplies up to a total of three months. Supervisory approval must be obtained for any planned purchases of prescribed drugs and/or medical supplies beyond this timeframe.
(b) Payment will be made for generic type drugs unless the physician specifically requests a brand name drug.
(c) Durable medical equipment does not fall within the category of prescribed medical supplies and the provisions of this section do not limit its purchase.

612:10-7-105. Hearing aids

~~(a)~~ Hearing aid(s) may be purchased for those eligible persons for whom an aid(s) is recommended. If diagnostic examinations recommend a hearing aid(s) for a client, arrangements are made for the client to return to a licensed audiologist for a hearing aid evaluation. The evaluation will determine the type of hearing aid which can best serve the client.
~~(b) The Medical Assistance Unit of the Department of Human Services normally provides hearing aids for those eligible persons under age 21. The counselor can provide this service if the client is nearing working age and a definite vocational program can be formulated.~~

612:10-7-106. Hospitalization

Hospitalization may be authorized for a client when recommended by a physician and the client is to receive medical treatment or surgery. Hospitalization may also be authorized for diagnostic services upon recommendation of a physician ~~and if approved by the supervisor~~.

612:10-7-109. Low vision service

~~(a) Improvement of residual vision is one of the most important services made available to individuals with severe visual impairments.~~ Applicants for low vision services must have an initial eye examination prior to referral. The conditions in (1) - (3) of this Subsection serve as guidelines for selecting referrals for low vision services:

(1) Visual acuity with corrected refraction poorer than 20/80.
(2) Condition stable or slowly progressive.
(3) Individual motivated to utilize residual vision.

~~(b) When it is found the individual can profit by special lenses, the individual is referred to an appropriate vendor.~~

612:10-7-111. Medical services for individuals under age 21 [REVOKED]

~~The Medical Assistance Unit (MA) of the Department of Human Services has primary responsibility for the provision of medical services for eligible individuals under age 21. Before DRS medical services, other than diagnosis, are provided, eligibility of persons under age 21 for medical services under the Medical Assistance Unit of the Department of Human Services must be determined. Exemptions are:~~

~~(1) The medical services needed are not within the scope of MA services. Results of the MA application or the reason why a MA application was not considered must be well documented in the case folder.~~
~~(2) The individual will reach age 21 before the necessary services can be completed. These individuals will be age 19 or above and no longer enrolled in high school.~~
~~(3) There is an IPE at the time the need for medical services arises and delay in the provision of medical services will interrupt or delay achievement of the individual's employment outcome.~~

612:10-7-112. Nursing services

(a) Nursing services can be provided for a client who is convalescing from physical restoration services if recommended by the doctor of treatment. Either Registered Nurses or Licensed Practical Nurses may be used to provide this service when a current medical vendor agreement is on file with the Department. Volunteers may be used if less technical care is needed and if approved by the client's physician.

(b) Before providing any nursing service outside the hospital, the counselor will determine if the service is available from any other source.

~~(c) The provision of this service requires Supervisory Approval.~~

612:10-7-117. Psychiatric and psychological treatment

(a) Psychotherapy may be provided for emotional conditions which may be expected to respond within a reasonable period of time. Psychotherapy can be provided only by the sources in (1) - (5) of this Subsection.

(1) Psychiatrists certified by the American Board of Psychiatry and Neurology or completed the required training and are "Board Qualified", or who have spent a major portion of their time in a particular specialty for at least two years and are recognized as specialists in the local community (same criteria as applied to other medical specialists).

(2) Licensed Doctors of Medicine or Doctors of Osteopathy who have received specific training for and are experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(3) Psychologists with a doctorate in clinical or counseling psychology who hold a valid license to practice psychology.

(4) Psychologists with a doctorate in clinical or counseling psychology who are employed by governmental agencies exempt from the licensing law.

(5) Other licensed clinicians or those employed by governmental agencies who have received administrative approval to provide this treatment service.

(b) Treatment may be purchased for a period not to exceed three months. Upon receipt of a written report from the therapist, ~~the supervisor may approve~~ additional three-month periods may be authorized. Long-term psychiatric or psychological treatment is outside the scope of vocational rehabilitation services. Clients needing long-term or ongoing psychiatric or psychological treatment will be referred to the appropriate community mental health center.

(c) Personal Adjustment Counseling may be provided for those persons with emotional conditions who may benefit from counseling to bring about a more adequate social adjustment, alleviate superficial anxiety, and to create more effective interpersonal relationships. Personal Adjustment Counseling may be provided by: those individuals listed in (a) of this Section.

(d) Personal Adjustment Counseling may be purchased for a three-month period following approval of the IPE by the supervisor. Additional three-month periods may be provided upon review of a written report from the therapist ~~and approval of the supervisor.~~

PART 13. SUPPORTIVE SERVICES

612:10-7-130. Maintenance

(a) **General guidelines.** Maintenance is a supportive service provided to assist with the out-of-ordinary or extra expenses to the individual resulting from and needed to support the individual's participation in diagnostic, evaluative, or other substantial services in the IPE. Maintenance, including payments, may not exceed the cost of documented expenses to the individual resulting from service provision. Authorizations for maintenance will not be issued to pay the cost, or part of the cost, for any other service or expense.

(b) **Provision of maintenance.** To receive maintenance, an individual must be either an eligible DVR or DVS client or an applicant for vocational rehabilitation services undergoing diagnostic evaluation and testing. For an accepted client, maintenance must be a supportive service related to ~~intermediate objectives or~~ outcomes listed in the Individualized Plan for Employment. The costs of the maintenance may not exceed the amount of increased expenses that the IPE causes for the individual or his/her family. The provision of maintenance as a supportive service is not synonymous with general assistance payments. It is not intended to pay for those living costs that exist irrespective of the individual's status as a DVR and DVS client. Maintenance payments must be carefully tied to the achievement of specific VR ~~intermediate~~ outcomes which must be stated and documented in the case record and the IPE to justify such payments. Maintenance cannot substitute for or supplement income assistance payments.

(1) **Maintenance for diagnostic and evaluation services.** Maintenance payments for individuals receiving diagnostic or evaluation services may be authorized for overnight care, short-term lodging and/or meals.

(2) **Maintenance for physical restoration services.** Maintenance for physical restoration services is paid to the client until he/she is able to work. The client must be in his/her own home and the covered period of convalescence is to be 60 days or less. For convalescent periods in excess of 60 days, the counselor will refer the client to other sources for assistance (public assistance, SSI). In no instance will medical maintenance be paid while the client is hospitalized.

(3) **Maintenance for training.** Maintenance can be authorized for full time vocational school students or college students. Maintenance can be authorized for a client granted an exception to the full-time attendance requirement under 612:10-7-150(a). ~~A copy of the authorization is sent to the supervising counselor.~~

(4) **Maintenance for job search services.** Maintenance for job search services requires an IPE with major services directed toward the goal of employment. ~~The client can receive a one month maintenance check and, with supervisory approval, two additional months during the life of the case.~~

(5) **Maintenance for job relocation.** Maintenance may be paid to a client for assistance in relocating to a new job site. Maintenance services for this purpose must be identified on the IPE.

(c) **Clothing expenses.** Clothing and/or uniforms can be purchased when needed to begin training or enter employment. ~~The amount authorized cannot exceed a total amount of $400.00 during the life of the case. Purchases in excess of this amount require supervisory approval.~~ Everyday clothing needs of the client are considered as part of the basic living requirements. Any clothing purchased for the client must be:

(1) required by the training facility;

(2) necessary to participate in job search or begin employment; or

(3) necessary to begin a training program that requires clothing standards beyond the client's means.

(d) **Day care expenses.** Day care expenses will be paid for from DVR and DVS funds only when necessary to participate in the IPE, and it is fully documented that no other resources are available for this service, including family members and friends.

612:10-7-131. Transportation

Transportation, including adequate training in the use of public transportation vehicles and systems, may be provided for a client as a service to enable the client to receive diagnosis, evaluation or other rehabilitation services. Authorizations for transportation will not be issued to pay the cost, or part of the cost, for any other service.

(1) **Public transportation.** The authorization is made directly to the vendor or client for actual cost.

(2) **Private transportation.** ~~Transportation allowance will only be provided if there is a clearly defined need to enable the client to participate in vocational rehabilitation. The amount of transportation allowance for the use of a private vehicle will take into account the individual's unique circumstances and any available comparable services and benefits. To compute the amount paid for transportation allowance, multiply the mileage for one trip by the number of trips; then multiply that number by the state daily average cost of gas per gallon; then divide this figure by the average gas mileage of the vehicle in question. The transportation allowance will be directly authorized to the client. Case narrative documentation is required explaining how the amount was determined. A client who receives a transportation allowance must present a valid driver's license, a copy of which must be maintained in the case record. If the client is not a driver, he/she must provide a plan to the counselor that describes how he/she will utilize family members or others as drivers for transportation to participate in vocational rehabilitation services. The counselor will document this in the case record~~ Mileage for use of a private vehicle is paid at 50% of the rate allowed by the State Travel Reimbursement Act and is authorized directly to the client. In these instances, mileage will be restricted to the most direct route and to the least possible number of trips. A payment of mileage is a service to enable the client to receive diagnosis, evaluation or other rehabilitation services. Case narrative documentation is required explaining how the amount was determined.

(3) **Vehicle Repairs.** Vehicle repairs will only be provided if there is a clearly defined need to enable the client to participate in vocational rehabilitation. Maintaining and repairing a private vehicle is primarily the responsibility of the owner. Assistance with vehicle repair is intended for emergency situations where services have been initiated under the IPE and participation in the IPE cannot continue without the repair. Generally, this will mean that the vehicle cannot be driven without the repair. The cost of vehicle repairs will not exceed $1,000.00 for the life of the case unless approved by the appropriate ~~Field Coordinator~~ program manager. All vehicle repairs will be directly authorized to the client including situations where the ownership of the vehicle is other than the client's. Clients requesting assistance with vehicle repairs must provide counselors with the driver's valid driver's license and current vehicle registration for the vehicle considered for repair. If the client is not a driver, he/she must provide a plan to the counselor that describes how he/she will utilize family members or others as drivers for transportation to participate in vocational rehabilitation services. Copies of these documents will be maintained in the case file. Prior to vehicle repair, clients will provide counselors with an estimate outlining the repairs and cost for counselor's approval. Upon completion of repairs, clients will provide counselors with a receipt verifying the completion of the repairs. Counselors will secure copies of the estimate and receipts for any repairs and these documents will be maintained in the case file.

(4) **Out-of-state/air transportation.** Transportation by airplane or out of state travel may be provided to allow a client to receive services not available in the state. Transportation may also be provided for a client to seek employment out of state provided the counselor has written documentation that the significance of the disability, or the nature of the vocational objective, makes in-state placement unusually difficult. The case must also contain documentation of efforts made to place the client with an appropriate in-state employer. If air fare is to be provided, arrangements for such fares will be made through the State Travel Coordinator, Department of Rehabilitation Services State Office.

(5) **Transportation for an attendant.** Transportation may also include the cost of travel for an attendant of an individual with a significant disability. Subsistence will be paid at the rates established by the State and described in OAC 340:2-1. The counselor will have an agreement with the client regarding allowable expenses before the trip is made.

(6) **Training for use of public transportation.** Expertise available within DVR and DVS, or within the community will be used to provide this service when possible. If this service must be purchased, the authorization is made directly to the vendor or client for actual cost.

PART 15. TRAINING

612:10-7-142. General guidelines for training services

(a) Training may be provided for clients who:

(1) are mentally, physically and/or emotionally capable of pursuing a course of training to completion;

(2) do not possess vocational skills which can be utilized for suitable employment within the disability limitations; and

(3) are determined to have a reasonable opportunity for obtaining employment in the chosen vocation.

(b) It is the policy of DVR and DVS not to assist clients in training beyond the requirements for the chosen vocational objective. DVR and DVS will only pay tuition and fees for courses which count toward requirements consistent with the vocational goal of the IPE. Training of DVR and DVS clients is provided by colleges, universities, private business and trade schools, state supported vocational schools, employers in the form of on-the-job training, sheltered workshops, and other approved training facilities with valid contracts.

(c) Federal regulations require a search for comparable services and benefits with the results documented before payment can be made for training in the following institutions: colleges, universities, community/junior colleges, public or private vocational/technical schools, or hospital schools of nursing. PELL grants and other available Federal/State student aid (excluding merit awards) must be applied to tuition, fees and all other educational expenses as a first dollar source prior to consideration of the expenditure of DRS funds.

(d) Training costs will not be authorized beyond the first DVR and DVS sponsored enrollment until proof of the availability of comparable benefits is received by the counselor.

(e) Once training has begun, the client is expected to progress toward the vocational objective at a steady rate. This requires the client to attend training on a regular basis, and maintain a full-time load to complete training in a minimum period of time. Sporadic attendance and reduced training loads causing a delay in the completion of training must be reviewed by the counselor.

(f) All types of institutional, technical, personal adjustment or employment training are purchased by an authorization, issued either by the field counselor or by a designated supervising counselor.

612:10-7-143. Coordination of training with other services [REVOKED]

~~The cost of training, transportation needs, supplies, equipment, maintenance, and specialized services will be considered during the development of the IPE. All of these services, whether provided by the Department, another agency or organization, the client or their family, are shown as a part of the IPE.~~

612:10-7-145. Counseling activities during training program

~~(a) **General considerations.** The counselor's responsibility in developing a training program with the client does not end with the inception of the training program. It continues throughout the length of the training period to oversee the progress toward successful completion.~~ The counselor assists the client in making needed adjustments during the training period and counsels with the client regarding any personal or vocational problems which threaten to impede the training program.

~~(b) **Examples.** Some of the types of supervision and counseling responsibilities of the counselor during the training period are:~~

(1) **Initiating the program.** Before the training program begins, the counselor must decide how much responsibility the client personally can accept for making arrangements for the training and auxiliary services. Clients are encouraged to make their own arrangements for lodging, meals, transportation, and the purchase of books and training materials.

(2) **Counseling during training.** The counselor has the important responsibility of keeping in touch with his clients and the training agencies to detect problems and resolve them. Early recognition of the client's problems and provision of counseling and other needed services can increase chances of success for a training program.

(3) **Counseling for employment.** Before the training is completed, the counselor and the client will discuss the steps necessary to find suitable employment. The counselor will determine the client's readiness for employment. Counseling techniques will include informing the client of available job openings, job search methods, and the client's responsibility in following through with these activities. The IPE will include plans for the counselor's active participation in the placement process and must be documented throughout the life of the case.

612:10-7-147. Special scholarships and training facilities [REVOKED]

~~(a) **Will Rogers Scholarship Fund.** Supplemental assistance from the Will Rogers Scholarship Fund is available to certain individuals with disabilities attending the University of Oklahoma. Application blanks may be secured for the Will Rogers Fund from the supervising counselor at Oklahoma University (OU). The home counselor will assist the client in the preparation of the application and forward it to the supervising counselor at OU. (Send one copy of the complete application for the scholarship and two copies of the case summary material.)~~

~~(b) **Training at Gallaudet University.** Gallaudet University, located in Washington, D.C., was established specifically for training individuals who are deaf. Each year, a few Oklahomans qualify for entry to college studies at this school. Qualified rehabilitation clients may attend this school if a valid contract is on file.~~

~~(1) Individual programs will be made in accordance with costs as listed in the current school catalogue. Due to the cost and the distance of the school from our state, careful planning must be done with the client. Special emphasis will be placed on securing grants and other financial assistance.~~

~~(2) Transportation costs may be provided for a one-way public coach fare with meals to Washington, D.C., at the beginning of school and for a return ticket at the close of~~

~~the semester and/or school year. The maximum allowable is for two round trips during a school year.~~

612:10-7-150. Continued eligibility for college or university training

(a) **Requirements for continued eligibility.** DVR or DVS clients in college or university training will be expected to attend classes regularly and make continuous progress toward graduation. To continue assistance with college or university training, the client must maintain a cumulative 2.0 grade-point average (GPA), based on a four point (4.0) scale. The client must carry the minimum number of semester hours determined to be full time at the school attended. Exceptions may be granted by the home counselor, based on severity of disability, scheduling problems, or other valid reasons. When a client fails to meet the requirements for continued sponsorship the guidelines in (1) - (5) of this Subsection are to be followed:

(1) Payment of training services based on client's financial status will not be provided if the client's grades fall below 1.5 cumulative GPA.

(2) Services may be paid for a client having a cumulative GPA between 1.5 and 1.9 for the first semester that grades fall below 2.0 cumulative GPA. Subsequent enrollments can only be paid if the student's cumulative GPA shows progress.

(3) A client failing to meet the grade point requirement may continue to receive services not based on financial status.

(4) A client failing to meet grade point requirements may be approved by the ~~home~~ counselor if there are extenuating circumstances beyond the client's control.

(5) A client failing to meet grade point requirements will be contacted as soon as appropriate to complete a program review to determine if a change in services, vocational goal, or objectives is needed. A client failing to meet chosen goals will not have his/her case closed until the counselor has provided counseling and guidance and determined that a change in the IPE is inappropriate. The counselor should investigate the need for further vocational and/or educational evaluation to explore alternative employment goals.

(b) **Withdrawals and failures.** Clients who withdraw or fail courses paid by DVR and DVS will be required to pay for a like number of hours during the following enrollment period subject to the guidelines in (a) of this Section.

(c) **Enrollment instructions:** Each ~~consumer~~ client is responsible for providing ~~either~~ their ~~home~~ counselor ~~or supervising counselor~~ a copy of the college or university's current semester costs before the designated "Drop and Add" date. No authorization for previous semester's costs will be issued.

612:10-7-151. Duration of college and university training

(a) It is the policy of DVR and DVS to assist clients in training for a particular vocation so the individual will have the skills needed to reach his or her full potential in that vocation in light of the individual's education, experience, abilities, interests, and limitations. For DVR and DVS clients pursuing a college or university degree, the Department will sponsor only the number of semester hours or remaining hours required for a specific degree.

(b) Previously completed credit hours which are applicable to the degree requirements will be incorporated in the development of the IPE. When a client changes majors, DVR and DVS funding will be limited to the number of credit hours needed for the new major minus the number of DVR and DVS funded credit hours lost due to the change in majors, unless the change in majors results from circumstances beyond the client's control. ~~All IPE's which include DVR and DVS funding of training beyond the bachelors degree level must be approved by the field coordinator.~~

612:10-7-152. Payment of tuition and fees at colleges and universities

(a) Tuition and fees for DVR and DVS clients attending colleges and universities will be paid at the rate set for resident students by the Oklahoma Regents for Higher Education and within limits prescribed by the Legislature. DVR and DVS will pay those fees charged to all students and special fees associated with required courses in the student's major field of study. ~~The supervising counselor of a particular school will authorize payment for these services. However, the home counselor will authorize payment for these services using a direct client payment when the client will be attending schools which do not have an assigned supervising counselor.~~ No authorization will be issued for tuition and fees until the client submits the applicable grade report, enrollment and award letter.

(b) Tuition and fees for students in attendance at accredited private or denominational schools will be paid at the same rate as that paid at state-supported colleges or universities of equal rank.

(c) Pell Grant and all other Federal/State aid (excluding merit awards) must be applied to tuition, ~~and~~ fees and all other educational expenses as a first dollar source prior to the consideration of the expenditure of DRS funds regardless of whether the student is attending a public or private institution of higher education.

~~(d) Any rehabilitation program which includes training beyond the bachelor's degree level must be approved by the field coordinator.~~

(~~e~~d) No approval for authorization will be issued for the current semester's cost after the college or university's designated "Drop and Add" date. No authorization will be issued for previous semester's costs.

612:10-7-153. Textbook allowance for college and university students

(a) A textbook allowance may be provided ~~for clients, based on the number of credit hours taken per semester, at a rate, established by the Oklahoma Commission for Rehabilitation Services. If the textbook allowance does not cover the total cost of necessary textbooks for any client, a direct client payment will be made to cover the balance~~ to cover the actual cost of required textbooks, supplies, tools or equipment, after

comparable benefits have been applied. The client will be required to furnish documentation of the ~~remaining balance before an authorization will be issued to cover it~~ costs of required books, supplies, tools or equipment. ~~When DRS provides a textbook allowance, the counselor will explain to the client that the warrant will not be issued until after enrollment due to authorization processing time.~~ The counselor will work with the client in obtaining and utilizing comparable benefits, including the PELL Grant, and planning for the use of other resources to help meet this expense. The textbook allowance will be adjusted the following semester for clients who fail or withdraw from courses paid by DVR and DVS. ~~The textbook allowance for books to be used for recording or reader services will be at actual cost of the textbooks.~~

(b) Only textbooks for the current semester's enrollment will be provided.

612:10-7-154. Allowance for durable training supplies for college and university students [REVOKED]

~~(a) An allowance for durable training supplies may be authorized to clients based upon actual cost. Clients will provide the supervising counselor an itemized list of required training supplies as verified by the instructor. The allowance will include only costs for those durable training supplies required for other students taking the class unless the client requires specialized adaptive supplies. As this allowance is issued on actual cost of the items, the supervising counselor will obtain a Receipt for Equipment and Title Agreement when the client receives durable training supplies costing $500 or more. The client, or client's family or authorized representative as appropriate, is responsible for maintaining durable training supplies in good working order. DVR and DVS will pay for repairs to durable training supplies purchased with DVR and DVS funds during the life of the case unless there is clear evidence the supplies have been damaged due to client abuse or neglect. Home counselors will be responsible for obtaining the itemized list of required training supplies, the Receipt for Equipment and Title Agreement, and will authorize for the required supplies for clients attending training facilities designated in the pilot program.~~

~~(b) Only supplies for the current semester's enrollment will be purchased by the VR counselor.~~

612:10-7-157. Out-of-state training

(a) Out-of-state training of DRS clients is approved when one or more of the following applies:

(1) The course of training is not available within the state;

(2) The out of state training program is no more expensive than in-state training; or

(3) There are specific considerations based on severity of the disability which preclude the use of in-state facilities.

(b) The case record is to document the basis for this determination.

(c) Individual counselors will be responsible for authorizing payment to out-of-state training facilities, unless a supervising counselor has been assigned for the training facility. Tuition for a student who attends an out-of-state college or university will be paid at the same rate paid at Oklahoma colleges or universities of equal rank. A textbook allowance and purchase of durable training supplies can be provided for clients in out-of-state training, utilizing procedures outlined in 612:10-7-153 ~~and 612:10-7-154~~.

(d) Documentation must state why the particular vendor is being used in terms of specific clients, and address the issues of:

(1) selection of vocational objective;

(2) projected starting and completion dates;

(3) breakdown of costs; and

(4) extent of comparable services and benefits.

(e) Prior to client's enrollment at a facility located in another state, an approved Justification for Out-of-State Training form must be submitted to the DRS State Office.

(f) The DRS Contracts Unit must complete renewal of contracts no less than two months prior to present contract expiration date to ensure continuation of services. When a contract lapses because renewal was not completed within time frames, the Department cannot pay the institution's claim.

612:10-7-159. Privately owned business and trade schools

(a) Training may be purchased for eligible clients from schools listed as approved in the contract log after full utilization of available comparable benefits such as PELL grants and other Federal/State student aid (excluding merit awards). Schools approved through the state board responsible for accrediting/licensing that particular type of school may be used to train clients following the processing and approval of a written purchasing agreement with the Department. If the school has not been used previously, then a written purchasing agreement must be obtained.

(b) Continued eligibility of a client in training at a privately owned business or trade school will be based on the client's performance in respect to grades, progress and attendance. Clients are expected to attend classes regularly and make continued progress toward completion while maintaining a C average as shown in the monthly training progress report. The standards used by the training facility and those set in DRS Policy for satisfactory progress, in respect to grades and attendance, will be utilized by DVR and DVS staff in determining the progress of the individual.

(1) DVR and DVS sponsored clients attending privately owned business and trade schools who withdraw or fail course work will be required to pay for like credit or clock hours during the following enrollment period.

(2) Students who fail to meet agency sponsorship guidelines for training at privately owned business and trade schools may continue to receive services not requiring client participation in cost.

(3) A client failing to meet agency sponsorship guidelines may be approved by the ~~home~~ counselor if there are extenuating circumstances.

(4) A client failing to meet agency sponsorship guidelines will be contacted as soon as appropriate to complete a program review to determine if a change in services, vocational goal or objective is needed. A client failing to meet chosen goals will not have his/her case closed until the counselor has provided counseling and guidance and has determined that a change in the IPE is inappropriate. The counselor should investigate the need for further vocational and/or educational evaluation to explore alternative employment goals.

612:10-7-161. Public and private vocational schools

~~(a) The State Department of Career and Technology Education has established vocational training schools at various sites across the state. These schools offer vocational training in a wide variety of areas. Every area vocational technical school with a valid written purchasing agreement is listed in the computerized contract file.~~

~~(b)~~ Continued eligibility of a client in training at a ~~public~~ vocational school will be based on the client's performance in respect to grades, progress and attendance. The minimum standards used by the training facility for satisfactory progress in respect to grades and attendance will be utilized by DVR and DVS staff in determining the progress of the client.

(1) DVR and DVS sponsored clients attending ~~public~~ vocational technical schools who withdraw or fail course work will be required to pay for like credit or clock hours during the following enrollment period.

(2) A client who fails to meet agency sponsorship guidelines for training at ~~public~~ vocational technical schools may continue to receive services not requiring client participation in cost of services.

(3) A client failing to meet agency sponsorship guidelines may be approved by the ~~home~~ counselor if there are extenuating circumstances.

(4) A client failing to meet agency sponsorship guidelines will be contacted as soon as appropriate to complete a program review to determine if a change in services, vocational goal or objective is needed. A client failing to meet chosen goals will not have her/his case closed until the counselor has provided counseling and guidance and has determined that a change in the IPE is inappropriate. The counselor should investigate the need for further vocational and/or educational evaluation to explore alternative employment goals.

612:10-7-162. Supplies and training tools for business, vocational and trade schools

(a) Required books, supplies, and training tools may be purchased for clients attending a facility with a valid contract, after full utilization of available comparable benefits such as PELL grants and other Federal/State student aid (excluding merit awards). Gun "kits", but not operable firearms, used as training tools may be purchased for students in gun-smithing school only. The client, or client's family or authorized representative as appropriate, is responsible for maintaining supplies and training tools in good working order. DVR and DVS will pay for repairs to supplies and training tools purchased with DVR and DVS funds during the life of the case unless there is clear evidence the supplies or training tools have been damaged due to client abuse or neglect.

(b) The Department retains title to any tools costing $500 or more purchased for training purposes until title is released by an authorized agent of the Department. The supervising counselor will complete the Receipt for Equipment and Title Agreement, and obtain necessary signatures, before releasing such tools to the client. Any tools purchased for training purposes remain with the client while he/she is in training and after the completion of the training if they can be used in the client's chosen vocation. If the client drops out of training, the supervising counselor and/or home counselor will make every effort to repossess the tools to transfer to another client.

(c) Case recording must reflect the disposition of tools and materials provided the client before the case is closed.

612:10-7-163. On-the-job training

(a) When on-the-job training will best suit the client's needs, this type of training can be considered. In order for the client to gain work experience and obtain employment, OJT can be provided in conjunction with any other DRS service. This service does not require client participation in cost of services.

(b) In selecting on-the-job training sites, the counselor must assure the items in (1) - (6) of this Subsection are met:

(1) The ~~individual~~ business or ~~business~~ individual must have enough work to provide the client sufficient training.

(2) The business or individual must be able to provide proper equipment.

(3) The individual who actually does the training must be the employer~~,~~ or an employee of the business~~,~~ and have the knowledge, skill, and ability to train the client.

(4) Time must be devoted daily to the training of the client.

(5) It is expected the client will be employable after a reasonable period of training.

(6) ~~The trainer must be willing to pay the client for work done after an initial period of training~~ The employer must be willing to consider the client for any open position, full or part time, after the initial training period.

~~(c) The counselor must ensure the client does not become a subsidized employee. The client can be expected to do some productive work, but the trainer must realize the primary goal is to learn a vocation.~~

(~~d~~c) There is no specific length of time for on-the-job training, as the length of time needed for training will vary with the complexity of the job being learned.

(~~e~~d) Individuals and businesses which provide on-the-job training are expected to ~~abide by the Wage and Hour Laws applicable to their particular businesses. If the business is subject to the Wage and Hour Law,~~ compensate OJT participants according to applicable minimum wage and hour regulations under the Fair Labor Standards Act. ~~the trainer~~ The employer must pay the client at least the applicable minimum wage unless the counselor issues a sub-minimum wage certificate. This permits the employer to pay less than the minimum wage for a specified period of time if the client has a severe disability.

(~~f~~e) On-the-job training payments are ~~not to be used as~~ reimbursement for~~, or in lieu of~~ wages ~~or~~ and benefits paid by the employer. ~~There is no relation between the tuition rate paid to the employer and wages paid to the client. Tuition~~ Reimbursement is paid to the ~~trainer~~ employer who pays the client just like his or her own employees. It is not permissible for the ~~trainer~~ employer to endorse the ~~tuition~~ reimbursement check and give it to the client in lieu of wages.

(~~g~~f) ~~Tuition~~ Reimbursement for on-the-job training is paid on a monthly basis.

612:10-7-164. Personal and work adjustment training

(a) Personal and/or work-adjustment training is provided ~~on a work site or in an approved Community Rehabilitation Program. Community Rehabilitation Programs~~ by facilities having valid contracts with the Department~~ are listed in the contract log~~. Personal and/or work adjustment training may also include (but is not limited to) activities aimed toward work tolerance, development of personal habits, attitudes, and work habits necessary to orient the individual to the world of work.

(b) Personal or work adjustment training is the provision of skills or techniques for the purpose of enabling the individual to compensate for the loss of a member of the body or the loss of sensory function. Personal or work adjustment training includes conditioning ~~(sometimes referred to as to work hardening)~~ activities for developing work tolerance, work therapy, occupational therapy, lip reading, speech training and speech correction, auditory training, gait training, diabetes management courses, driver's training, and mobility training. This service does not require client participation in cost of services.

612:10-7-168. Duties of home counselor [REVOKED]

~~The home counselor is responsible for developing an IPE with specific services outlined for reference by the supervising counselor and to send training information in a timely manner. All supportive services necessary for the client to enter training must be arranged by the home counselor. The home counselor has the responsibility to keep the supervising counselor informed of any changes in the client's case status. The home counselor will advise the client of his or her responsibilities during training. The home counselor must assist the client in location and application for comparable benefits. The home counselor will advise the client no approval for authorization will be issued to the college or university after the current semester's "Drop and Add" period. No back payments will be issued for previous costs. The supervising counselor assumes the duties of home counselor for any cases transferred to the supervising counselor. The home counselor will assume supervising counselor responsibilities for clients attending any colleges or universities in the designated pilot program.~~

612:10-7-169. Duties of counselors who supervise clients in training facilities [REVOKED]

~~(a) Each training facility in the state utilized by DRS is assigned a supervising counselor. This assigned counselor is the authorizing agent for all services provided and purchased at that facility. The home counselor will assume supervising counselor responsibilities for clients attending any of the designated training facilities for the pilot program. This counselor's duties include the activities in (1) - (13) of this Subsection.~~

~~(1) Advise agency staff of enrollment dates and where clients will complete enrollment.~~

~~(2) Meet with students at the beginning of each semester or training period for the purpose of counseling and obtaining a copy of the client's enrollment.~~

~~(3) Authorize tuition to the school and prepare claims. Authorize textbook allowance and supplies directly to the client in appropriate cases. (See 612:10-7-153 and 612:10-7-154). Services will not be authorized until the supervising counselor has a copy of the IPE and supporting documents on the client, including comparable benefits award letters which apply to the enrollment in question.~~

~~(4) Send copies of all authorizations, grade reports, current enrollment and counseling reports to the home counselor.~~

~~(5) Monitor client progress to be sure the client takes courses that will lead to the stated objective.~~

~~(6) Notify the client's home counselor of the need for any change in the client's IPE. It will be the home counselor's responsibility to actually amend the IPE.~~

~~(7) Act as liaison between the client, home counselor, and the training facility in all matters.~~

~~(8) Notify the home counselor if the client fails to continue training and, if possible, provide an explanation.~~

~~(9) Notify the home counselor whenever it appears a maintenance and/or transportation check needs to be suspended or cancelled due to nonattendance. While it is generally the responsibility of the home counselor to suspend or cancel authorizations, there may be instances when it would be to the agency's advantage for the supervising counselor to cancel an authorization. In this case, copies of the affected authorizations will be forwarded to the home counselor.~~

~~(10) Make the decision regarding probation when the client's cumulative grade point average falls below 2.0. The supervising counselor must inform the home counselor and client of the action taken.~~

~~(11) Advise the home counselor of any new benefits or changes in amounts of financial assistance being received by the client through grants.~~

~~(12) In the event of intercurrent illness, the supervising counselor may approve the provision of the required services and authorize for the same. Circumstances of this type must be brought to the attention of the home counselor as soon as possible.~~

~~(13) No approval for authorizations will be issued after the college or university's current semester's "Drop and Add" date. No back payment for previous semester's costs will be issued.~~

~~(b) The training facility may dictate the extent the duties in (a) (1) through (13) of this Section may be carried out and the methods used. To function effectively, rapport must be established between the facility personnel, home counselors, and~~

~~clients. This will require both flexibility and good judgment on the part of the supervising counselor.~~

PART 21. PURCHASE OF EQUIPMENT, OCCUPATIONAL LICENSES AND CERTIFICATES

612:10-7-220. Vehicle modification services

(a) Vehicle modification services may be provided as needed to enable a Vocational Rehabilitation client to prepare for, enter or retain employment. Vehicle modifications include the range of modifications and special equipment needed by a person with an impairment to drive or be a passenger in a vehicle.

(b) Vehicle modification services provided to an individual in the Vocational Rehabilitation program may include:

(1) purchase and installation of adaptations or devices in a vehicle;

(2) assistance with payment of the portion of the cost attributable to modifications pre-installed in a new or used vehicle purchased from a dealer;

(3) evaluation of an individual's ability to operate a motor vehicle;

(4) prescription of required devices specific to both the individual's needs and the vehicle; and

(5) training in the operation of the vehicle.

(c) Vehicle modifications which are projected to cost ~~$2,500~~ the amount of the DCS authority order limit or less will be made in accordance with 612:10-1-7. Vehicle modifications projected to cost more than ~~$2,500~~ the DCS authority order limit will require additional processing by DRS Central/Departmental Services after the process is completed by the counselor as outlined in Categories A through E below. The counselor is required to submit the requisition, the authorization, the bid documents if applicable and all supporting bid documentation if applicable for Purchasing to award the Purchase Order. Once the Purchase Order is received by the counselor, the vendor can be notified of the award. Categories A through D will be purchased in accordance with this section. Clients purchasing new vehicles shall apply for any mobility equipment rebate available from the vehicle manufacturer and the amount of any such rebate shall be assigned to DRS.

(1) Category A: New Vehicle with structural modifications: In this process, the vehicle will be purchased by client choice and not obtained through a bid process. The client will be responsible for the purchase of the vehicle and DRS will be responsible for the costs attributable to the structural modifications.

(2) Category B: New Vehicle with structural modifications and accessibility modifications additions: In this process, the vehicle will be purchased by client choice and not obtained through a bid process. The client will be responsible for the purchase of the vehicle and DRS will be responsible for the costs attributable to the structural modifications and the accessibility modification additions.

(3) Category C: Used Vehicle with structural modifications: In this process, the vehicle will be purchased by client choice and not obtained through a bid process. The client will be responsible for the purchase of the vehicle and DRS will be responsible for the costs attributable to the structural modifications and the accessibility modification additions. DRS will participate in this method only if the client obtains warranty from the mobility aids vendor. A copy of the warranty agreement will be obtained by the counselor and maintained in the case file.

(4) Category D: Used Vehicle with structural modifications and accessibility modifications additions: In this process, the vehicle will be purchased by client choice and not obtained through a bid process. The client will be responsible for the purchase of the vehicle and DRS will be responsible for the costs attributable to the structural modifications and the accessibility modification additions. DRS will participate in this method only if the client obtains warranty from the mobility aids vendor. A copy of the warranty agreement will be obtained by the counselor and maintained in the case file.

(5) Category E: Any modifications to a new or used vehicle not purchased as part of the vehicle package will require additional processing by C/DS after the bid process is completed by the counselor in accordance with 612:10-1-7.

(d) Some clients with significant disabilities will not have a valid driver's license. These clients are to be referred to the Department of Public Safety for determination of whether the client is able to obtain a license. Arrangements will be made by the counselor for the individual to take special driver's training following acquisition of the driving permit. If the client is to drive the vehicle, equipment will not be purchased until the client has a valid driver's license and the client has successfully completed training in the use of the special equipment for his/her vehicle.

(e) The qualifications in (1) - (9) of this Subsection apply to all vehicle modifications.

(1) The client or individual providing the transportation must have a current, valid driver's license.

(2) A used vehicle must be inspected by an ASE or manufacturer certified mechanic to assure it is mechanically and structurally sound before equipment can be installed. This inspection may be authorized by the counselor, if necessary. If the AWSE or manufacturer certified mechanic recommends it, a separate inspection related to structural soundness will be completed. This inspection may be authorized by the counselor.

(3) The name of the client must appear on the title to the vehicle and current vehicle registration. The client may be listed as a co-owner on these documents.

(4) The vehicle must be evaluated by an Assistive Technology Specialist or person with equivalent qualifications (Driver Rehabilitation Instructor, Occupational Therapist, Rehab Engineer, etc.) for identification of the appropriate adaptive equipment and assessment of the compatibility of the vehicle with recommended adaptive equipment. Existing modifications on a new or used vehicle shall be inspected for the appropriateness of the adaptive equipment for the consumer's need by the Assistive Technology Specialist or other qualified person. DRS

also requires documentation that existing modifications on a used vehicle have been inspected by the mobility equipment dealer/vendor to determine efficiency, quality and fair market value of the modification or adaptive equipment. This documentation may be obtained directly from the mobility equipment dealer/vendor or from the lender when such documentation has been required for loan approval.

(5) Vehicle modifications provided by the agency must be limited to those modifications and adaptive devices which are required to meet the client's need.

(6) The client must agree to retain ownership of the vehicle and maintain the vehicle for the predictable life of the equipment. The counselor completes the Receipt for Equipment and Title Agreement and has the client sign it, as per guidelines in 612:10-1-7(e).

(7) The client must maintain both collision and comprehensive insurance on the vehicle, including the equipment.

(8) DRS will not pay the expense of replacing the equipment unless the equipment no longer meets the needs of the client based on disability related issues, as determined through review of current medical reports and assistive technology evaluation indicating replacement is required to meet the IPE goals.

(9) Certain types of vehicle modification equipment are considered "transferable" by design: i.e., hand controls, left foot accelerator, and hitch lift systems for wheelchairs/scooters. DRS may assist with the cost of transferring this type of equipment to meet the IPE goals. These modifications are categorized as non-structural modifications.

(f) When vehicle modifications are completed, installation is to be inspected by an Assistive Technology Specialist or person with equivalent qualifications, to determine if the authorized equipment conforms to prescribed standards, is properly installed, and meets the functional needs of the client. The A.T. Specialist will inform the counselor if the installation is satisfactory and ready for delivery to the client. The counselor must also obtain a statement of satisfaction from the client.

(g) The client is responsible for maintaining special equipment for vehicles in good working order. DRS may pay for repairs to such equipment during the life of the case unless there is clear evidence the special equipment has been damaged due to client abuse or neglect as determined by the dealer, vendor or Assistive Technology Specialist.

PART 23. SELF-EMPLOYMENT PROGRAMS AND OTHER SERVICES

612:10-7-230. Self-employment programs

Self-employment programs may be divided into ~~Small Business Enterprises~~ Contract Labor~~,~~ and ~~the Business Enterprise Program~~ Self-Employment.

(1) ~~**Small Business Enterprise**~~ **Contract Labor.** Employment is contract labor when the client has a contract or on-going business with a company or person to provide a specific product or service for a fee. The service or product is produced to meet the vendor's specifications and needs. The purchasing company often supervises the work. ~~Small Business Enterprise refers to a small business operated by an individual with a disability. Such businesses must include suitable and practical work activities for the most effective utilization of the skills and aptitudes of the person with disabilities. It will provide employment commensurate with the client's time, cost, and other economic factors. Plans of this nature in excess of $10,000 require supervisory approval. Services of this type may be provided if the criteria in (A) and (B) of this Paragraph are met.~~

(2) **Self-Employment.** In Self-Employment, the consumer owns, manages and operates a business selling goods or services for the purpose of making a profit, ex: (Business Enterprise Program). Self-Employment ranges from sole proprietorships and independent contractors to multi-employee companies and independent franchise operations.

(A) The client must have ~~has~~ the proper skills and managerial ability to succeed in the trade or occupation for which the services are provided; and

(B) The client must have ~~has~~ adequate resources available for the proper maintenance and upkeep of the required tools, equipment, and stocks. The client is responsible for the maintenance and repair of any tools, equipment, and stocks.

~~(2) **Business Enterprise Program.** The Business Enterprise Program refers to those services available to establish vending facilities for persons who are blind or visually impaired through the Randolph-Sheppard Act as described in OAC 612:25.~~

612:10-7-230.1. Definitions [REVOKED]

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

~~**"Contract Labor"** Employment is contract labor when the client has a contract or ongoing business with a company or person to provide a specific product or service for a fee. The service or product is produced to meet that vendor's specifications and needs. The purchasing company often supervises the work.~~

~~**"Self-Employment"** Self-Employment is defined as follows: The consumer owns, manages and operates a business selling goods or services for the purpose of making a profit. Self-employment ranges from sole proprietorships and independent contractors to multi-employee companies and independent franchise operations.~~

~~**"Self-employment costs"** The cost of starting and maintaining or retaining the business as addressed in the business plan. This does not include training, business plan development, assistive technology, or disability related job site or vehicle modifications, which are addressed as separate services in the Individualized Plan for Employment.~~

~~**"Small Business"** DRS defines small business as any approved business plan under $100,000.00.~~

612:10-7-230.2. Self-Employment Guidelines

(a) **Agency Role.** The role of the VR Agency is not to become the funding source for self-employment endeavors. DRS may participate in partially funding small business start-up or the retention of an existing consumer owned and operated business, but does not have a capital or loan program for the establishment or retention of businesses. These investment resources must come from other sources. DRS will assist the consumer in making informed decisions, reduce or eliminate the barriers created by the disability(ies), training regarding small business development/self-employment, and assisting the individual in identifying possible funding resources.

(b) **When to Consider Self-employment.** The counselor may consider self-employment as an employment goal when all of the following guidelines have been met.

(1) The income derived from a self-employment plan is to be the primary source of support.

(2) It is the consumer's informed choice consistent with their unique strengths, resources, priorities, concerns, abilities, capabilities and interests.

(3) When a consumer expresses interest in self-employment, the individual will be required to participate in a vocational assessment with focus on self-employment potential. The assessment will include a self-evaluation completed by the client.

(4) The counselor will document, as appropriate, in the comprehensive assessment that the client has the academic, communication and managerial skills to manage their own business and the resources to demonstrate a likelihood of success.

(c) Once it has been determined that self-employment is a feasible goal, an IPE will be written to further assist the self-employment concept and the client is sent to training for developing a business plan. ~~the counselor will follow DRS Policy regarding self-employment/business plans.~~

612:10-7-230.3. Self-Employment/Business Plans

(a) Each individual, requesting Agency assistance with self-employment, is required to complete and submit a business plan that details at a minimum the following:

(1) Complete description of the proposed business.

(2) Business objectives.

(3) Ownership.

(4) Market Analysis.

(5) Marketing Plan.

(6) Financial Management Plan including personal finance sheets, projected expenses and income for at least 2 years.

(7) Specific listing of needed start-up costs and equipment, not including assistive technology devices.

(8) Specific listing of the type and amount of assistance the consumer is requesting from the State VR Program.

(9) Information regarding cost and coverage of insurance policies to cover liability, inventory, and equipment.

(b) Counselors will refer individuals to the local Small Business Development Center for assistance in developing a business plan. As appropriate the counselor may utilize other technical assistance services to aid the consumer in developing the business plan. After the plan is completed, the business plan will be reviewed by the appropriate DRS personnel.

(c) If the individual has submitted a viable business plan and the cost of the business plan to the agency, is $10,000.00 or less the counselor may approve the request. If the agency's cost will exceed $10,000 the counselor will refer the request to their immediate supervisor for approval.

(d) Certain individuals may require on-going supports or services for a business plan to be successful. The counselor will assist the individual in identifying and securing these support services. DRS cannot be responsible for funding these supports following successful employment outcomes.

612:10-7-230.4. Agency financial contribution to self-employment/ purchasing

(a) The agency may provide some financial assistance toward self-employment plans that have met the requirements as specified in policy. The counselor will determine the client's financial status and any required financial participation by the client. The agency's contribution will not exceed 25% of any approved plan request above $10,000.00. The client's contribution may come from personal resources, property, loans, PASS plan funds or small business start-up grants from other assistance programs.

(b) Any required client financial participation is applied to the cost of planned services

(c) Self-employment plans exceeding $10,000.00 will require supervisory approval. Any request for assistance that will include agency funding over $15,000.00, will be submitted to the Field Coordinator for review and approval or disapproval.

(d) Items that the agency will not approve for funding include:

(1) Construction or purchase of real estate.

(2) Businesses that are speculative in nature such as stocks, bonds or other investments or considered speculative by the Better Business Bureau.

(3) Businesses that are organized as not for profit.

(4) Businesses organized as hobbies

(5) Purchase of vehicles

(6) Refinancing of existing debt.

(7) Business plans that are not developed as the primary source of support.

(8) A business endeavor that does not have an agency approved business plan.

(e) **Purchases and support services.** All Agency purchases for a plan with a goal of self-employment will be in accordance with established purchasing policy regarding the competitive bid process and referrals to the State Office Purchasing Unit. Any requests for assistance with maintenance or transportation will be required to meet established policy guidelines for these support services.

612:10-7-230.5. DRS Monitoring

(a) The counselor will continue to be available for technical assistance upon completion of approved purchases. Counselor will review with consumer every 3 months the progress of the business. This will include copies of the businesses profit and loss statements and record of business performed. The purpose of these reviews is to determine if the involvement in self-employment is allowing the consumer to substantially increase his/her earnings to achieve self-employment success and be able to meet on-going financial obligations of the business. Should the business not be showing an increase in the income of the consumer, the counselor will review, with the consumer, the consumer's business plans to try to increase the business income. If necessary, the consumer may be referred to the small business development center or similar program for technical assistance in making changes in business operation to achieve a business profit.

(b) Stated in the IPE, this case would be agreed upon as a successful closure~~,~~ if the business is stable after 90 days~~,~~ and has met the specified level of performance ~~when the client is able to perform activities required for maintaining self-employment~~. At the time of case closure, title for all goods purchased by the agency will be released to the consumer.

[OAR Docket #10-751; filed 5-4-10]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES CHAPTER 20. SPECIAL SCHOOLS

[OAR Docket #10-752]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 2. Contracted Instructional Personnel
612:20-2-11. Admonishment [AMENDED]
612:20-2-14. Immediate suspension of a teacher [AMENDED]
612:20-2-16. Administrators; suspension [AMENDED]
612:20-2-17. Full-time administrators; Appeal of dismissal or nonreemployment [AMENDED]
AUTHORITY:
The Oklahoma Commission for Rehabilitation Services; Rehabilitation Act, United States Code Title 29, sections 701 through 791; Oklahoma Statute Title 74, Section 166.1 et seq.
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N/A
INCORPORATIONS BY REFERENCE:
N/A
ANALYSIS:
The agency no longer has a Deputy Director and is not likely to ever have one again. Those duties have been assigned to the Chief of Staff.
CONTACT PERSON:
Ray Leard, Administrative Programs Officer, Policy Development, Department of Rehabilitation Services, 3535 N.W. 58th, Suite 500, Oklahoma City, OK 73112 (405) 951-3406

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, 2010:

SUBCHAPTER 2. CONTRACTED INSTRUCTIONAL PERSONNEL

612:20-2-11. Admonishment

(a) When an administrator who has the responsibility of evaluating a teacher identifies poor performance or conduct that the administrator believes may lead to a recommendation for the teacher's dismissal or nonreemployment, the administrator shall, after consulting with the Superintendent:

(1) Admonish the teacher, in writing, and make a reasonable effort to assist the teacher in correcting the poor performance or conduct; and

(2) Establish a reasonable time for improvement, not to exceed two (2) months, taking into consideration the nature and gravity of the teacher's performance or conduct.

(b) If the teacher does not correct the poor performance or conduct cited in the admonition within the time specified, the administrator shall make a recommendation to the Superintendent for the dismissal or nonreemployment of the teacher.

(c) Whenever the Director, ~~Deputy Director~~ Chief of Staff, Superintendent or a school administrator identifies poor performance or conduct that may lead to a recommendation for dismissal or nonreemployment of a teacher, the administrator who has responsibility for evaluation of the teacher shall be informed, and that administrator shall comply with the procedures set forth in this section. If the administrator fails or refuses to admonish the teacher within ten (10) calendar days after being so informed by the Director, ~~Deputy Director~~ Chief of Staff, Superintendent or other school administrator, then the Superintendent shall admonish the teacher pursuant to the provisions of this section.

(d) Repeated negligence in performance of duty, willful neglect of duty, incompetency, instructional ineffectiveness or unsatisfactory teaching performance, for a career teacher, or any cause related to inadequate teaching performance for a probationary teacher, shall not be a basis for a recommendation to dismiss or not reemploy a teacher unless and until the provisions of this section have been complied with.

(e) In determining whether or not the professional performance of a teacher is adequate, the standards adopted by the State Board of Education shall be considered. Consideration may be given to any written standards of performance which have been adopted by any other education-oriented organization or agency. Professional performance or conduct of a teacher which is in compliance with standards adopted by the State Board of Education or the Department of Rehabilitation Services shall not be considered in support of any dismissal or nonreemployment against the teacher.

612:20-2-14. Immediate suspension of a teacher

(a) **Cause unrelated to a criminal charge or indictment.**

(1) Whenever the superintendent has reason to believe that cause exists for the dismissal of a teacher and is of the opinion that the immediate suspension of the teacher would be in the best interests of the children in the school, the superintendent, ~~Deputy Director~~ Chief of Staff or Director, after receiving the recommendation for suspension from the superintendent, may suspend the teacher without notice or hearing. However, the suspension shall not deprive the teacher of any compensation or other benefits to which the teacher is otherwise entitled.

(2) The suspension shall extend to such time as the teacher's case is decided in a hearing as provided for at OAC 612:20-2-13. However, such extension shall not include time for judicial review or any other appeal process.

(3) Within ten (10) calendar days after the suspension of a teacher, the Director shall initiate proceedings for dismissal pursuant to the relevant provisions of this subchapter.

(b) **Cause related to a criminal charge or indictment.**

(1) If the cause for dismissal is related to a criminal charge or indictment against the teacher, the suspension may extend to such time as the criminal case is finally adjudicated at trial. However, such extension shall not include any appeal process.

(2) If the cause for dismissal is related to a criminal charge or indictment against the teacher, the Director may at any time initiate proceedings for dismissal pursuant to the relevant provisions of this subchapter.

612:20-2-16. Administrators; suspension

(a) **Cause unrelated to a criminal charge or indictment.**

(1) Whenever the Director, ~~Deputy Director~~ Chief of Staff or Superintendent believes that a reason exists for the dismissal of an administrator and that the immediate suspension of the administrator would be in the best interests of the children in the school, the Superintendent, ~~Deputy Director~~ Chief of Staff or Director may suspend the administrator without notice or hearing. However, the suspension shall not deprive the administrator of any compensation or other benefits to which he or she would otherwise be entitled under his or her contract pursuant to law.

(2) Within ten (10) calendar days after the suspension becomes effective, the Director shall initiate proceedings pursuant to the relevant provisions of this subchapter to have the administrator dismissed.

(b) **Cause related to a criminal charge or indictment.**

(1) If the reason for dismissing the administrator is related to a criminal charge or indictment against the administrator, then the suspension may be extended to such time as the criminal case is finally adjudicated at trial. However, the extension shall not include any appeal process.

(2) If the reason for dismissing the administrator is related to a criminal charge or indictment against the administrator, then the Director may at any time initiate proceedings pursuant to the relevant provisions of this subchapter to have the administrator dismissed.

612:20-2-17. Full-time administrators; Appeal of dismissal or nonreemployment

(a) Whenever the Director, ~~Deputy Director~~ Chief of Staff or Superintendent shall determine that the dismissal or nonreemployment of an administrator from his/her administrative position should be effected, the administrator shall be notified in writing of the proposed action. The notice shall state the reason(s) for taking the action and shall inform the administrator of his/her right to a hearing before the Director or the Director's designee prior to the dismissal or nonreemployment.

(b) The administrator may request a hearing within ten (10) calendar days after receipt of the notice of proposed dismissal or nonreemployment. If the administrator fails to request a hearing within the ten-day period, then the administrator will have waived the right to such a hearing. The request for a hearing shall be made in writing to the Director and sent by certified mail, return receipt requested, or by substitute process as provided for by law.

(c) Upon the receipt of a timely request, the Director shall schedule a hearing to take place no more than ten (10) calendar days after receipt of the request. The Director shall notify the administrator of the hearing by certified mail, return receipt requested, or by substitute process as provided for by law. The notice shall include a statement of the reasons for the recommendation for dismissal or nonreemployment, the facts underlying the recommendation, and a statement of the legal authority and jurisdiction under which the hearing is to be held.

(d) The Director or the Director's designee shall serve as the hearing officer. The hearing shall be an individual proceeding pursuant to the Oklahoma Administrative Procedures Act (70 O.S. § 250 et seq). Discovery may be conducted by the parties pursuant to the Oklahoma Administrative Procedures Act. The hearing officer shall be authorized to issue subpoenas pursuant to 75 O.S. § 315.

(e) The hearing shall be tape-recorded and a copy of the tape shall be provided the administrator upon request.

(f) If the hearing officer is the Director's designee:

(1) The hearing officer shall deliver to the Director a decision within three (3) workdays after the conclusion of the hearing. The decision shall include findings of fact and conclusions of law, separately stated. The hearing officer shall decide by a preponderance of the evidence whether

reason(s) exist for the dismissal or nonreemployment of the administrator.

(2) In deciding whether to dismiss or to not reemploy the administrator, the Director shall take the hearing officer's decision into consideration and shall independently review the record of the case. The Director shall issue a final agency order regarding the dismissal or nonreemployment of the administrator within five (5) workdays after the date of the hearing officer's decision. The Director shall notify the administrator of the order by certified mail, return receipt requested, or by substitute process as provided for by law. The order shall include findings of fact and conclusions of law separately stated.

(g) If the Director serves as the hearing officer, the Director shall issue a final agency order regarding the dismissal or nonreemployment of the administrator within five (5) workdays following the conclusion of the hearing. The Director shall notify the administrator of the order by certified mail, return receipt requested, or by substitute process as provided for by law. The order shall include findings of fact and conclusions of law separately stated.

(h) The administrator may seek a rehearing, reopening or reconsideration of the final order pursuant to the Oklahoma Administrative Procedures Act at 75 O.S. § 317.

(i) In the event that an administrator is dismissed or the administrator's contract is not renewed, the Director shall notify the administrator of the right to trial de novo within ten (10) days of the receipt of the final order of the Director. The petition for a trial de novo must be filed within 10 days of receipt of the final order of the Director.

[OAR Docket #10-752; filed 5-4-10]

TITLE 712. OKLAHOMA COMMISSION FOR TEACHER PREPARATION CHAPTER 10. TEACHER PREPARATION PROGRAM ACCREDITATION

[OAR Docket #10-687]

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PERMANENT final adoption
RULES:
Subchapter 5. Teacher Preparation Program Accreditation
712:10-5-1 [AMENDED]
712:10-5-2 [AMENDED]
712:10-5-3 [AMENDED]
712:10-5-4 [AMENDED}
Subchapter 7. Teacher Preparation Teacher Assessment
712:10-7-1 [AMENDED]
Subchapter 9. Professional Development Institutes
712:10-9-1 [AMENDED]
Subchapter 11. Education Leadership Oklahoma
712:10-11-1 [AMENDED]
Appendix A. Competency Exam Requirements by Certification Areas [REVOKED]
Appendix A. Competency Exam Requirements by Certification Areas [NEW]
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Oklahoma Commission for Teacher Preparation
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INCORPORATIONS BY REFERENCE
n/a
ANALYSIS:
The rule requires institutions that offer programs in elementary, early childhood education, or special education report annually to OCTP the results of the comprehensive assessment of teaching skills in the area of reading instruction which is administered to all candidates in these programs. The rule also aligns program review and unit accreditation decisions and terminology with those of the National Council for Accreditation of Teacher Education (NCATE). The rule also establishes assessment requirements for examinees seeking certification via the Alternative Placement program or by the additional certification route. The rule provides clarification for funding and serving on the selection committee of Education Leadership Oklahoma scholarships. It replaces outdated criteria for professional development with the updated requirement of scientifically research-based professional development. The rule also includes language from House Bill 1837 that requires OCTP to establish an Inner City Rescue Program and to promulgate rules for implementation.
CONTACT PERSON:
Ted Gillispie, Executive Director, 3545 NW 58th Street, Suite 200, Oklahoma City, Ok 73112-4725, 405-525-2612

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FOR THE IN 75 O.S., SECTION 308.1 (A), WITH AN EFFECTIVE DATE OF JULY 1, 2010:

SUBCHAPTER 5. TEACHER PREPARATION PROGRAM ACCREDITATION

712:10-5-1. Teacher Preparation Program Accreditation And Review Process

(a) Oklahoma teacher education institutions function under an 'accreditation program' system which requires the evaluation of teacher education units and programs on a periodic basis.

(b) Beginning July 1, 1997 institutions which have no accredited teacher education program and which desire to initiate a certificate program shall follow the format outlined herein based on Standards for Oklahoma Accredited Teacher Education Programs and Institutional Plan (see 712:10-5-3).

Institutional plans are defined as plans developed and prepared utilizing input from education stakeholders (teacher preparation faculty, arts and science faculty, teacher candidates, teachers, administrators, business and community leaders, and parents) which follow the general guidelines and standards for pre-service teacher preparation programs outlined in sections 712:10-5-3. On July 1, 1997 the Oklahoma Commission for Teacher Preparation, hereafter referred to as the Commission, shall assume responsibility for accrediting all teacher education programs in Oklahoma's public and private institutions of higher education.

(c) The program accreditation system shall be a multifaceted system based on:

(1) A competency-based teacher preparation program built around the Standards for Oklahoma Accredited Teacher Education Programs and State Department of Education Competencies, herein after referred to as SDE;

(2) Institution plans as outlined in the Standards for Oklahoma Accredited Teacher Education Programs and Institution Plan Format;

(3) On-site accreditation review team visits to the campuses of the institutions of higher education;

(4) Analysis of data related to student success rates on the general education, professional education, and subject matter assessments;

(5) Analysis of student satisfaction data;

(6) Analysis of student/teacher candidate portfolios.

(d) Beginning January 1, 1997 all institutions of higher education with teacher education programs must submit an initial institutional plan outlining how the institution will respond to those standards identified in the Oklahoma Standards for Accredited Teacher Education Programs and Initial Institution Plan (See 712:10-5-3, and OS 70 sections 6-199 through 6-202.)

(1) All initial plans will be reviewed by the Program Accreditation Committee, hereafter referred to as the PAC and recommendations forwarded for first accreditation, accreditation with provisions, continuing accreditation, accreditation with ~~stipulations~~ conditions, continuing accreditation with probation, or denial of accreditation will be forwarded to the Commission within sixty days of submission.

(2) All PAC members and a minimum of ten prospective members will receive performance training on how to evaluate the initial plans. Only those members demonstrating proficiency in evaluation will be allowed to evaluate the plans.

(3) The performance-based training will be conducted by the National Council for Accreditation of Teacher Education, hereinafter referred to as NCATE and/or their designee.

(4) Any Commission member or Commission appointee who is involved in any evaluation and/or accreditation decision related to any teacher education unit and/or program must complete the performance-based training related to the review and accreditation of teacher education units and/or programs prior to voting and/or participating on any accreditation decisions.

(5) Prior to being accredited each institution must meet the NCATE preconditions for accreditation and all requirements of the OCTP, and/or receive the approval of the OSRHE when applicable, and provide required documentation for each precondition.

(A) The institution is an equal opportunity employer and does not discriminate on the basis of race, sex, color, religion, age, or handicap (consistent with Section 702 of Title VII of the Civil Rights Act of 1964, which deals with exemptions for religious corporations, with respect to employment of individuals with specific religious convictions).

(B) A copy of the institution's official action pledging compliance with nondiscriminatory law and practice.

(e) Beginning July 1, 1997 the Commission will become a performance-based partner with the Oklahoma State Regents for Higher Education (State Regents) and NCATE. All teacher education programs shall be expected to meet all NCATE unit and program standards, SDE competencies, as well as all additional standards established by the Oklahoma Commission for Teacher Preparation.

(1) **Application form.** The application form containing the required information will be completed by the director of teacher education at the institution seeking Commission accreditation for the teacher education certificate programs.

(2) **Institutional plan.** The institutional plan shall be utilized by the Commission for program accreditation, State Regents program review, and NCATE accreditation. An institutional plan addressing the standards as outlined in the Oklahoma Commission for Teacher Preparation Standards for Oklahoma Accredited Teacher Education Programs and Institution Plan and criteria established in these rules and as stipulated in OS 70 sections 6-180 through 202 will be sent to the Commission office along with the application form.

(3) **Records to be kept on file at the institution.** The following items and records shall be kept on file at the institution with the director/dean of teacher education.

(A) Copy of the institution plan;

(B) Comments from the annual public forum held by the institution, the responses to comments, and how the comments were utilized in the modifications of the program;

(C) Copy of annual report to the Commission;

(D) Syllabi for courses in the areas of specialization, general education, and professional education will be kept on file with the institution; and

(E) Full faculty resumes will be on file for review. All levels of teaching personnel will be indicated.

(F) Copies of program review reports.

(G) Candidate CEOE scores.

(4) Timelines for evaluation process.

(A) The Oklahoma Commission for Teacher Preparation personnel will establish an accreditation visit schedule in collaboration with the State Regents,

NCATE and the institution dean/director of teacher education.

(B) Upon approval by the governing board of the institution, two copies of the institution report and supporting materials including the college catalog shall be sent to the Commission office 75 days prior to the accreditation visit. Upon receiving the names and addresses of the visiting accreditation review team, the institution shall send copies of all documentation to the members of the visiting accreditation review team.

(C) The visiting committee selection process shall be completed a minimum sixty (60) days prior to the accreditation visit.

(D) The on-site accreditation evaluation will be conducted over a three to five day period.

(E) After finalizing the team draft report which results from the accreditation visit, and within fourteen days of the accreditation visit, the team chair shall send the draft report to team members and Commission professional personnel for editing.

(F) Within twenty-one days of the visit the team members and the Commission office shall return their comments and recommendations on the report to the team chair. The chair makes corrections to the report, as appropriate, and sends a copy to the unit head at the institution for factual corrections.

(G) Within twenty-eight days of the visit but not less than five days of the receipt of the report the unit head sends factual corrections in writing to the team chair. The chair makes changes at his/her discretion, finalizes the report and sends one copy to the Commission office. The report shall be in the format determined by the Commission.

(H) The Commission staff will copy ~~and bind~~ the report with a cover that includes the name of the institution, its location, and the date of the visit.

(I) Utilizing the procedures outlined in 712:10-5-1(e)(8) the Commission will make a final decision regarding the accreditation of the institution's certificate program(s). That decision will be based on the findings and recommendations of the Commission Program Accreditation Committee and any additional information which may be presented by the institution under review.

(J) All certification program reviews must be submitted to NCATE or to the Commission no later than 18 months prior to the first accreditation visit and 12 months prior to a continuing accreditation visit.

(5) **Selection of accreditation review team.** Selection of the accreditation review team will be coordinated by the Commission staff as soon as possible after the visitation dates are set. All accreditation review team members shall be determined within eight weeks prior to the accreditation review team visit. Selection of the accreditation review team shall be based on the following:

(A) All team members must have been trained by NCATE Board of Examiners and/or their designee in the assessment of NCATE standards and on the process for evaluating programs for the Commission.

(B) The membership of a first accreditation review team shall be as follows:

(i) Three to six representatives from the NCATE Board of Examiners (for NCATE accredited institutions).

(ii) State representatives appointed by the Commission including:

(I) One pre-K-12 classroom teacher;

(II) One representative from higher education who is a member of a teacher education unit. For accreditation of private institutions the representative shall be from a private institution; for public institutions this representative shall be from a public institution;

(III) One representative from the Commission;

(IV) One additional at-large member;

(iii) For any institution requesting accreditation of a career technology program(s) an additional accreditation review team member may be recommended by the State Director of Career and Technology Education.

(iv) Special Circumstances:

(I) For accreditation review teams requiring fewer members the Executive Director of the Commission shall collaborate with the Program Accreditation Committee, the director of teacher education at the institution being accredited, and NCATE and Commission staff to determine the team composition.

(v) Observers shall be determined by the Commission and from among representatives of the Oklahoma State Regents for Higher Education, State Department of Education, State Department for Career and Technology Education, professional organizations, and the community-at-large.

(I) Observers shall be actively involved in the data collection process, participate in the accreditation review team meetings, and assist the accreditation review team to understand state nuances. They may assist, but shall not be required to write any sections of the team report. They shall not be a voting member of the team.

(II) Observers are expected to participate in the entire visit and all assigned meetings and activities.

(III) The chair of the accreditation review team has the authority to dismiss any observer from the accreditation visit who does not participate in the entire site review and assigned activities.

(C) Accreditation team for continuing accreditation. The membership of a continuing accreditation review team shall be as follows:

(i) NCATE representatives as determined by NCATE (for NCATE accredited institutions);

(ii) State representatives which will number one less than the NCATE representatives;

(iii) The Executive Director for the Commission for Teacher Preparation or his/her designee shall collaborate with the director of teacher education at the institution being reviewed, NCATE, and with the PAC and Commission staff to determine the state committee representation;

(iv) Observers shall be determined by the Commission and from among representatives of the Oklahoma State Regents for Higher Education, State Department of Education, and the community-at-large. If a Career and Technology program is offered at the institution the State Director of Career and Technology Education shall nominate a team member for any institution requesting accreditation of career and technology program(s);

(v) Observers shall be actively involved in the data collection process, participate in the accreditation review team meetings, and assist the accreditation review team with understanding state nuances. They may assist but shall not be required to write any sections of the team report. They shall not be a voting member of the team.

(vi) Observers are expected to participate in the entire visit and all assigned meetings and activities.

(vii) The chair of the accreditation review team has the authority to dismiss any observer from the accreditation visit who does not participate in the entire site review and assigned activities.

(D) Accreditation teams for non-NCATE accredited institutions shall be composed of state representatives.

(E) The Executive Director for the Commission for Teacher Preparation or his/her designee shall collaborate with the director of teacher education at the institution requesting state accreditation, NCATE, the State Regents, PAC and Commission staff to determine the team representation.

(6) **Logistics of the accreditation visit.**

(A) Each institution shall arrange through the Commission for a pre-visit with the chair of the accreditation review team. The pre-visit should be conducted a minimum of sixty days prior to the team visit. The team chair must have received institutional report prior to the pre-visit.

(B) If it is to be a joint NCATE and Commission visit, the state chair, the NCATE chair and the Commission staff member responsible for program accreditation shall be included in the pre-visit. Logistical arrangements shall be finalized during the pre-visit.

(C) For state accreditation only, the state chair and the Commission staff member responsible for program accreditation shall be included in the pre-visit. Logistical arrangements shall be finalized during the pre-visit.

(D) A visitation schedule will be prepared and distributed approximately four weeks prior to the scheduled visit. The schedule will be developed cooperatively by the director of teacher education and the Commission staff in cooperation with the team chair(s).

(E) The following stakeholders shall be interviewed during the accreditation visit:

(i) Key faculty from the teacher education and the arts and sciences units;

(ii) Administrators from the university teacher education and the arts and sciences units;

(iii) Other individuals identified by the institution;

(iv) Students (both in organized group settings and in informal settings such as in hallways, student lounges, student union, etc.);

(v) Field supervisors and cooperating teachers of student teaching and internships;

(vi) Practitioners from area schools including, but not limited to, principals, school personnel directors, and teachers; and

(vii) Recent graduates.

(F) The individuals to be interviewed should be representative of the student body being served, consideration shall be made relative to ethnicity, gender, age and individuals with disabilities. Individuals being interviewed, unless unit and/or institution faculty members and administrators, shall not be employed in the unit. This shall not apply to field supervisors receiving stipends for their services.

(G) The visitation schedule shall include:

(i) Dates of the accreditation visit;

(ii) Name, location, telephone number of lodging where reservations have been made for committee members;

(iii) Location of visiting team headquarters on the campus of the institution being evaluated;

(iv) Meeting time and place for team organizational meeting;

(v) Meeting time and place for formal team interviews with constituencies listed in 712:10-5-1(e)(6)(E);

(vi) Meeting time and place for team to complete writing assignments;

(vii) Meeting time and place for team to present the exit report; and

(viii) Fax, telephone, and e-mail addresses of members of the unit.

(H) The completed accreditation review team report will be presented to the PAC, NCATE (as applicable), and the Commission.

(I) Visiting team members will be reimbursed for expenses incurred according to state guidelines. Reimbursement forms must be completed by team members on the last day of the visit.

(7) **Preparation of the team report.** The accreditation review team work will culminate in preparation of a report outlining the findings of the team. Individual writing assignments will be completed prior to the conclusion of the visit. The report will reflect the team consensus on the review.

(A) The accreditation review team report is to be based on the following:

(i) Validating and supporting documents, through interviews with students, faculty members, administrators, and school personnel;

(ii) Validating the institution plan by visiting facilities and reviewing documents; and

(iii) Specific guidelines and competencies for accredited teacher education programs.

(B) At the exit report, representatives of the accreditation review team will present a summary of its evaluation of the program. The summary will include findings for each standard and state requirement including areas for improvement.

(C) The completed reports will be due to the NCATE and Commission office 30 days after the accreditation review team on-site visit; and

(D) The recommendation of the accreditation review team regarding the program will be made to the PAC and the Oklahoma Commission for Teacher Preparation within 90 days after having received the rejoinder [see 712:10-5-1(e)(8)(B)(iv)]. For NCATE accredited institutions, final accreditation decisions will be made after the NCATE Unit Accreditation Board has forwarded its accreditation decision to the Commission.

(8) Recommendation process.

(A) Two copies of the final draft of the accreditation review team report will be forwarded to the Commission and one copy to each of the accreditation review team members who will be given the opportunity to suggest corrections in their respective assignment areas. Additionally, the director of teacher education will be given the opportunity to offer input regarding corrections in factual information.

(B) The head of the unit, in consultation with the chief executive officer of the institution, is required to acknowledge receipt of the report and is given the opportunity to prepare a rejoinder to the accreditation review team report. The unit can file the rejoinder and supplemental materials pertinent to the facts and conclusions found in the report of the accreditation review team.

(i) The institutional rejoinder to the accreditation review team report is a vital part of the evidence that the PAC considers as it makes its determination regarding first and continuing accreditation. The PAC considers the first/continuing accreditation report, accreditation review team report and the institutional rejoinder as it prepares its recommendations for the Program Accreditation Committee and subsequently to the full the Commission. The PAC may affirm the accreditation review team citations in areas for improvement or modify them based on evidence provided in the institutional rejoinder or to bring consistency to its decisions across institutions.

(ii) The purpose of the rejoinder is to clarify information presented in the accreditation review team report and to correct any factual errors in the report. If the judgments of the accreditation review team are being appealed by the unit, the rejoinder must indicate the grounds for such a stance and the available documentation to support it. This information should be summarized, cited, and included in an appendix as appropriate. The rejoinder should be concise, to the point, and complete.

(iii) The following conditions must be adhered to as the institutional rejoinder is prepared by the unit:

(I) All evidence must describe what existed at the time of the accreditation visit. Changes made by the unit after the visit cannot be considered by the PAC in its deliberations. Changes after the visit should be reported to the Commission for Teacher Preparation as part of the unit's annual report;

(II) All evidence must relate directly to NCATE standards, state requirements, and all procedures that applied at the time of the accreditation visit;

(III) The rejoinder must be factual in nature. All inaccurate information in the accreditation report should be corrected and appropriate documentation submitted with the rejoinder; and

(IV) When the unit does not respond, in writing, to the unmet standards and weaknesses in the accreditation report, the PAC assumes that the unit concurs with the accreditation review team citation and decision.

(iv) The institutional rejoinder should contain the following:

(I) Letter from the unit head to the Commission Executive Director acknowledging the receipt of the accreditation report;

(II) Responses to the areas for improvement. If there is evidence that an area for improvement does not exist, the appropriate documentation should be appended;

(III) Perceptions of procedural concerns, if any, regarding the accreditation review team review or process that might have prejudiced the accreditation review team judgments; and

(IV) Appendices that contain information to support any requests for reconsideration of the accreditation review team judgments. If the data were included in the institutional report

and not given adequate consideration by the accreditation review team, the appropriate pages should be cited/reproduced; if the reference exceeds three pages in the institutional report, the page numbers should be cited and not duplicated.

(v) The institutional rejoinder must be submitted to the Oklahoma Commission for Teacher Preparation within 30 days of the receipt of the accreditation review team report. When accreditation review team reports are sent to an institution during semester breaks, additional time to prepare the rejoinder will be considered. Additional time beyond the date indicated in the transmittal letter must be approved by the Commission Executive Director.

(C) Final action on the reports and institutional accreditation will proceed according to Section 712:10-5-1(e).

(D) Final action by the Commission may include the following actions:

(i) First and Continuing Accreditation

(I) First accreditation or continuing accreditation is granted to the education unit and program(s) if the Commission finds that standards have been adequately addressed to merit accreditation. This accreditation decision indicates that the unit meets each of the six NCATE standards for unit accreditation. Areas for improvement may be cited, indicating problems warranting the institution's attention. In its subsequent annual reports, the unit may describe progress made in addressing the areas for improvement cited in NCATE's action letter in preparation for its next visit. In its annual report the institution will be expected to address progress on the areas for improvement cited in the Commission accreditation report. This progress will be reviewed, annually, by the PAC. First accreditation is retroactive to the semester in which the accreditation visit occurred.

(ii) Provisional Accreditation (First).

(I) This accreditation decision indicates that the unit has not met one or more of the standards. When the PAC renders this decision, the unit has accredited status; but must satisfy provisions by meeting previously unmet standard(s) within an established time period.

(II) If provisional accreditation is granted, the PAC will require (1) submission of documentation that addresses the unmet standard(s) within six months of the accreditation decision or (2) a focused visit on the unmet standard(s) within two years of the semester of the accreditation decision. When a decision is made by the PAC to require submission of documentation, the institution may choose to waive that option in favor of the focused visit within two year. If documentation is submitted under the terms specified in the above paragraph, the PAC may (1) grant accreditation or (2) require a focused visit within one year of the semester in which the documentation was reviewed by the PAC. After a focused visit, the PAC will (1) grant accreditation or (2) revoke accreditation.

(III) If accreditation is granted, the next on-site visit is scheduled for five years following the semester in which the accreditation visit occurred.

(iii) Accreditation with Conditions (Continuing).

(I) This accreditation decision indicates that the unit has not met one or more of the NCATE standards. When the PAC renders this decision, the unit maintains its accredited status, but must satisfy conditions by meeting the previously unmet standard(s) within an established time period.

(II) If accreditation with conditions is granted, the PAC will require (1) submission of documentation that addresses the unmet standard(s) within six months of the accreditation decision or (2) a focused visit on the unmet standard(s) within two years of the accreditation decision. When a decision is made by the PAC to require submission of documentation, the institution may choose to waive that option in favor of the focused visit within two years. If documentation is submitted under the terms specified in the above paragraph, the PAC may (1) continue accreditation or (2) require a focused visit within one year of the semester in which the documentation was reviewed by the PAC. After a focused visit, the PAC will (1) continue accreditation or (2) revoke accreditation.

(III) If accreditation is granted, the next on-site visit is scheduled for seven years following the semester in which the continuing accreditation visit occurred. This scheduling maintains the unit's original seven-year accreditation cycle.

(iv) Accreditation with probation (Continuing).

(I) Continuing Accreditation with Probation is issued if the unit has serious and significant areas for improvement related to the Standards for Oklahoma Accredited Teacher Education Programs. As a result of the continuing accreditation review, the PAC has determined that areas for improvement with respect to standards will place an institution's accreditation in jeopardy if left uncorrected.

(II) All students who have been admitted to the program must be notified by mail, within 30

days of receipt of the PAC/Commission decision, as to the probationary accreditation status of unit and/or programs.

(III) For an institution that is placed on probation an accreditation visit must be scheduled by the institution and take place within two years of the semester in which the probationary decision was rendered. The professional education unit will remain accredited at least until the result of the rescheduled accreditation visit is known. This visit will mirror the team composition process for first accreditation. All Oklahoma standards for accreditation of the teacher education unit and/or programs in effect at the time of the visit must be addressed by the unit, as part of this visit. Following the review, the PAC may decide to (1) continue accreditation, (2) continue accreditation with conditions, or (3) revoke accreditation.

(v) Denial of accreditation (First).

(I) Denial of accreditation is rendered when the PAC finds that the professional education unit and/or programs have severe and/or numerous areas for improvement that limit its capacity to offer quality programs.

(II) All students who have been admitted to the program must be notified by mail, within 30 days of receipt of the PAC/Commission decision, as to the denial of program accreditation of the unit and programs.

(III) Institutions that are denied accreditation may recommend candidates for certification for one year from the end of the semester in which accreditation is denied.

(vi) Revocation of accreditation (Continuing).

(I) Revocation of accreditation terminates current accreditation after a two-year probationary visit if the PAC/Commission finds that critical areas for improvement are not corrected. Accreditation will be terminated at the end of the semester in which the PAC/Commission revokes accreditation.

(II) All students who have been admitted to the program must be notified by mail, within 30 days of receipt of the PAC/Commission decision, as to the revocation of accreditation of the unit and programs.

(III) Institutions that lose their accreditation may recommend candidates for certification for one year from the end of the semester in which accreditation is revoked.

(IV) An on-site interim accreditation visit may be requested by the Appeals Board, hereinafter referred to as AB, acting on behalf of the Commission Administrative Committee. This visit would result from the committee's determination that compelling reasons exist to authorize reexamination of the accreditation of an institution's professional education unit and/or programs. If the AB determines that a complaint received by the committee needs to be investigated, the committee will authorize an interim accreditation review team visit to the campus. The interim accreditation review team will consist of one member from the first or continuing accreditation review team and the remainder of the members will be appointed by the PAC following the guidelines outlined in 712-10-5(e)(5).

(V) The interim accreditation review team will prepare a report for the PAC. At the next PAC meeting following such a visit, the PAC will determine the institution's accreditation status.

(VI) The Commission may revoke accreditation if the unit and/or program(s) (a) no longer meets the Standards For Oklahoma Accredited Teacher Education Programs, (b) fails to submit annual reports and other documents required for accreditation; (c) misrepresents its accreditation status to the public; (d) fails to meet timelines of conditional or probationary accreditation or (e) fails over a three-year period to meet and maintain teacher candidate performance standards on the competency-based assessments as established by the Commission

(VII) All accreditation decisions shall be reported annually in the Commission annual report to the Education Oversight Board and all entities as outlined in OS 70 section 6-186.

(VIII) In the event that accreditation is denied or revoked, an institution may reapply for first accreditation following a three-year waiting period. Before an first visit may occur, a minimum of three years must have lapsed since accreditation was denied. Reapplication shall occur based on the Standards for Oklahoma Accredited Teacher Education Programs and Institutional Plan (See 712:10-5-3). All procedures for first accreditation will be followed during the reapplication process.

(9) **Appeals Board.**

(A) For NCATE accredited units the AB shall consider the recommendations of the NCATE appeals board for unit accreditation,

(B) For appeals related to program(s) and non-NCATE accredited institutions the following procedures shall be followed.

(C) Membership of Commission appeals board shall be:

(i) Commission chair. The Commission Chair shall be the Chair of the Appeals Board;

(ii) Chair of Program Accreditation Committee;

(iii) Program subject matter and/or standards expert(s). If the appeal is related to a specific program, the program expert shall be in the area(s) being appealed;

(iv) One PK-12 school classroom teacher;

(v) One member from the NCATE Board of Examiners (when applicable);

(vi) One teacher educator; and

(vii) One representative from the arts and sciences faculty or from school administration.

(D) The appeals board shall serve an initial term of two years, with the exception of the Commission Chair, Chair of the Program Accreditation Committee, and the program expert(s).The program subject matter expert(s) shall be appointed by the Commission Chair and serve on the AB only when an appeal is related to a program(s) appeal.

(10) **Conditions for appeals.**

(A) Any institution that is the object of an adverse decision, as determined by one of the Commission teacher education program review committees and/or unit accrediting committees, may appeal that decision to the Commission Appeals Board.

(B) An adverse decision is defined as the denial or revocation of program(s) or unit accreditation.

(C) An institution may also appeal, in writing, a provisional, conditional or probationary accreditation decision. Provisional, conditional or probationary accreditation does not terminate accreditation. An adverse decision may be appealed only on the following grounds:

(i) Stated procedures were not followed;

(ii) Evidence favorable to the institution was provided to the accreditation review team but was not considered;

(iii) Evidence was presented to the appropriate board in the form of a rejoinder or stipulation response but was not considered;

(iv) If a college or university believes that one or more of these conditions was a factor in its accreditation, the only available means of redress is through the appeals process; or

(v) There was a lack of the full number of team members due to last minute emergencies; however, that factor alone is not sufficient to uphold an appeal.

(I) The institution must convincingly demonstrate that this fact made a difference in the accreditation decision.

(II) The institution shall prove actual prejudice to it and that the prejudice changed the accreditation decision.

(III) The fact that the institution did not recommend canceling the visit would be evidence that it, at least before the visit, believed that the assembled team would be sufficient to conduct a fair and complete visit.

(D) The findings and recommendations of the AB are received by the full Commission at it first meeting following the meeting of the AB.

(E) Subsequent actions shall be based on grounds upheld by the full Commission and may include, but are not limited to:

(i) Assigning another accreditation review team to revisit an institution;

(ii) Reinstating accreditation or accreditation with provision, condition or probation; or

(iii) Upholding the initial recommendation for denial or revocation of accreditation.

(F) The status of the appellant at the time of the visit remains unchanged until the appeals process has been exhausted.

(11) **Process for appeal.** The following provisions govern the appellate process:

(A) Within 15 days of receiving notice of the adverse decision, an institution electing to appeal an adverse decision of the Commission must present the Commission Executive Director and the board or committee which issued the adverse or probation decision written notification of its intention to appeal.

(B) No later than 30 days from the date that it submits its notification, the institution must submit a brief to the Executive Director which sets forth the specifics of its appeal and includes full documentation.

(C) The Commission Chair shall convene the AB within 30 days after an appeal brief has been filed. The AB will hear and act on the appeal within this time frame.

(D) The appellant shall have the right to present a 30-minute oral argument on its brief. The appellant shall also have the right to be represented by counsel during the appeal, but may not call witnesses or introduce new evidence on its own behalf.

(E) If the adverse decision appealed is provisional, conditional or probationary accreditation, the appellant's right to appeal is limited to the submission of written documentation.

(F) In the case of an accreditation decision review, the AB has the right to seek clarification of the accreditation review team report from the state team chair, and clarification of the PAC's deliberations from the chair of the PAC.

(G) In the case of an accreditation decision review, all evidence presented in the appellant's brief and considered by the AB must be confined to conditions existing at the time of the accreditation review team visit as cited in the final report, or in the case of a petition for stipulation removal, to conditions existing at the time the petition for stipulation removal was submitted.

(12) **Cost of review.**

(A) If the appeal leads to an affirmation of the Commission's original decision, the appellant will be

liable for the expenses of the AB, the second accreditation review team visit, and all expenses related to the review. All expenses will be reimbursed according to state travel reimbursement guidelines.

(B) If the AB finds in favor of the institution, the Commission will be liable for expenses of the AB and second accreditation review team. All expenses will be reimbursed according to state travel reimbursement guidelines.

(C) Access to Documents. In cases of accreditation decision review, team chairs, and the PAC chair serving as witnesses to hearings of the AB will be provided copies of pertinent action letters and reports. Appellant petitions of appeals are provided to all witnesses.

(13) **Continuing accreditation procedures.** Seven-year continuing accreditation shall follow the same basic format as the NCATE Continuing Accreditation procedures. The accreditation review team will review such things as faculty qualifications and loads, financial support of the unit, follow-up procedures, clinical and field experiences, the residency program, faculty development procedures, and annual student assessment data.

(14) **Distribution of findings.**

(A) The accreditation review team chair shall ~~mail one copy~~ assure delivery of the final draft of its report to the Commission office.

(B) The Commission will coordinate with NCATE (for NCATE accredited institutions) for distribution of reports to other team members.

(C) After the institution has received the reports, it has 30 days to submit a rejoinder to the Commission according to procedures outlined in 712:10-5-1(e)(8)(B).

(D) When the entire process has been completed the Commission will distribute the findings to all interested stakeholders, including the State Department of Education and the Regents for Higher Education.

712:10-5-2. Structure of Accreditation Committees

(a) A Program Accreditation Committee (PAC) of the Oklahoma Commission for Teacher Preparation carries out the responsibilities for overseeing the accreditation or continuing accreditation of institution teacher education programs. Committee members shall be selected by the Oklahoma Commission for Teacher Preparation and approved by Commission membership to serve on such a committee. Except for the Commission Executive Director and program(s) subject matter experts, the initial term of membership shall be two years.

(1) Members shall have completed a training seminar related to state and NCATE accreditation and any other training deemed appropriate by the Commission.

(2) Membership shall be comprised of:

(A) A minimum of three Commission members who are not members of either an Accreditation Team or the Appeals Board;

(i) The Commission chair shall appoint PAC Chair(s) from the Commission members appointed to the PAC.

(B) Two pre-K-12 classroom teachers;

(C) The PAC chair(s) shall serve on the Commission Administrative Committee.

(D) Two teacher educators whose institutions will not be reviewed during the two-year term of appointment;

(E) One PK-12 public school administrator nominated by the State Superintendent of Public Instruction;

(F) One superintendent from an area-vocational school shall be nominated by the State Director of Career and Technology Education;

(G) Two arts and science faculty; one from a four year institution and one from a community college shall be nominated by the Chancellor for Higher Education; and

(H) The Commission Director of Program Accreditation shall serve in an advisory capacity.

(3) A minimum of two PAC members may be reappointed to additional terms to allow for continuity.

(4) Discretion and ethical judgment shall be used in making recommendations.

(5) Meeting dates shall be established in compliance with the following criteria:

(A) The PAC shall schedule a minimum of four meeting dates per academic year

(B) Other meetings shall be held as needed.

(C) Institutions with proposed programs for evaluation shall be notified of meeting dates four weeks in advance. Representatives from the institution(s) are encouraged to attend the meetings.

(6) Responsibilities and authority of the PAC shall be:

(A) Recognizing the status of all programs at each institution annually.

(B) Reviewing the Accreditation Team Report, reviewing the NCATE Unit Accreditation Board recommendations and recommending program accreditation status to the Commission;

(C) Following all procedures outlined in 712:10-5-1(e);

(D) Recommending to the Commission changes in administrative rules, regulations, policies. and procedures;

(E) Ensuring training for all accreditation review team members and PAC members;

(F) Carrying-out a systematic review and development of the standards by which programs are approved;

(G) Monitoring the performance of accreditation review team members; and

(H) Recommending training needs for accreditation review team members, institution faculty members, and PAC members.

(b) The Program Review Advisory Board (PRAB) shall provide consultation related to program reviews. The PRAB shall

make final reviews on all program reports and make recommendations on program status for all non-NCATE institutions and for program areas not associated with an NCATE-recognized learned society. Program reviews will take place in conjunction with the college's/university's five- or seven-year accreditation cycle, occurring 12 months prior to a continuing accreditation visit and 18 months prior to a~~n~~ first accreditation visit.

(1) Members of the Program Review Advisory Board (PRAB) shall be approved by the Program Accreditation Committee.

(2) The Program Review Advisory Board (PRAB) members shall serve an initial term of two years.

(3) Two or more of the Program Review Advisory Board (PRAB) members may be reappointed to additional terms to allow for continuity.

(4) Members shall have completed ~~a~~ training ~~seminar~~ on the program review process.

(5) Discretion and ethical judgment shall be used in making recommendations.

(6) The Program Review Advisory Board (PRAB) shall be comprised of trained reviewers in specific subject areas from the following groups:

(A) Practicing PK-12 classroom teachers

(B) Practicing PK-12 administrators

(C) Higher education faculty members

(c) The Commission Director of Program Accreditation or designee shall chair the Program Review Advisory Board (PRAB) committee.

712:10-5-3. Specific State Standards For Program Accreditation

(a) The following standards apply to both undergraduate and graduate programs. The governance and administration of the total teacher education program standard is based on the premise that there must be a recognizable and functioning governance entity within the institution's administrative structure which has responsibility for designing, approving and continuously evaluating and developing teacher education programs. This governing unit may be a council, committee, department, school, college, or any other recognizable entity, which includes the administration of teacher education as one of its functions.

(1) The governing unit membership and responsibilities include the following:

(A) Membership on the teacher education governing unit shall be defined by written policy to include:

(i) A majority of the members who have a minimum of three years teaching experience in public schools;

(ii) A majority of the members in the governance unit who are currently teacher education faculty members;

(iii) Some faculty members who shall represent the arts and sciences;

(iv) A designated director of teacher education defined as the institution's official representative for teacher education. The authority and responsibilities of this individual shall be clearly defined in written policies; and

(v) A clearly defined process whereby faculty members and administrators become members and the terms of office.

(B) The responsibilities of the teacher education governing unit shall be defined by written policy to include:

(i) Responsibilities of the officers of the unit;

(ii) Responsibilities of the unit's standing committees; and

(iii) Responsibilities in the following areas as they are related to teacher education:

(I) Admission/retention in teacher education;

(II) Field experience and student teaching (admission and placement);

(III) Development of courses and program curricula; and Program review, evaluation and planning.

(C) Program review, evaluation and revision responsibilities include:

(i) The governance unit shall conduct at least one systematic review, evaluation, and when appropriate, revision of all teacher education programs within each accreditation period;

(ii) The governance unit shall conduct an annual public forum pursuant to 712:10-5-1 and OS 70 section 6-185;

(iii) Periodic program reviews and revisions shall be based on, but not limited to, stated goals and objectives; and

(iv) The process for conducting program review, evaluation, and revision shall include, but not be limited to, participation by the following:

(I) Teacher education faculty and arts and science faculty;

(II) Graduates of the programs;

(III) Students currently in the program;

(IV) Teachers and administrators from the public schools;

(V) Parents of PK-12 students; and

(VI) Business and community leaders who are actively involved in assisting PK-12 schools.

(D) Documentation related to the budget-making process and level of financial support shall include the following:

(i) A clearly defined budget-making process for all teacher education programs; and

(ii) An analysis showing that the institution's financial support for programs in teacher education are maintained at a level appropriate for a professional preparation program.

(b) Teacher education faculty standards are to be consistent with accreditation standards.

(c) Student-related standards are to be consistent with accreditation standards.

(d) Program decisions of the professional education unit are to be guided by a conceptual framework, which establishes the shared vision for the preparation of teacher candidates.

(1) The conceptual framework must include the following structural elements: The mission of the institution and the teacher preparation program;

(A) The program's philosophy, purposes, professional commitments and dispositions;

(B) A knowledge base that provides the foundation for the framework;

(C) Performance expectations for candidates that align with professional, state and institutional standards; and

(D) A system by which candidate performance is regularly assessed.

(2) A description of the conceptual framework shall be submitted along with the institution's preconditions report by any institution seeking first accreditation.

(3) A description of the conceptual framework shall be included in all institutional reports submitted prior to first and continuing accreditation visits.

(e) The following guidelines are to be used to collect and maintain data on each institution's teacher preparation program:

(1) The institutional shall establish a process which seeks information and program input from teacher preparation faculty; faculty from arts and sciences and other program and disciplines which are appropriate; students within the teacher education program; teachers, administrators, parents, guardians or custodians of students; and business and community leaders.

(2) The institutional shall hold an annual public forum, subject to the provisions of the Oklahoma Open Meetings Act, regarding the content of the institutional plan; public comment on either the institution's teacher preparation plan or program will be solicited during the forum.

(3) The institutional plan shall be accessible to any interested party under the Oklahoma Open Records Act.

(4) The submitted institutional plan must be approved by the institution's governing board.

(5) Annual reviews and reports indicating program changes resulting from the evaluations.

(f) The following policies, procedures and guidelines are used to direct the content and candidates experiences of each institution's teacher preparation program.

(1) Programs require teacher candidates to have speaking and listening skills at a novice high level in a language other than English.

(2) General studies requirements for candidates include the arts, communication, history, literature, mathematics, philosophy, sciences, English, government, and the social sciences.

(3) Programs establish cohort or colleague groups within the institution to assist teacher candidates in achieving competencies, better adapting to the school environment and furthering professional growth.

(4) Candidates complete a well-planned sequence of courses and/or experiences in pedagogical studies that ensures student competency in the Oklahoma State Department of Education Full, Subject Matter Competencies for Teacher Licensure and Certification.

(5) The guidelines and standards for program reviews representing specialty organizations and national learned society standards are used in developing programs in each content area.

(6) Secondary and elementary/secondary teacher candidates have undergraduate majors or their equivalents, in a subject area.

(7) Teacher candidates in early childhood, elementary, and special education have subject area concentrations, which allow qualification as a generalist. To qualify as a generalist, candidates must document competency in mathematics, science, language arts, and social studies as identified in the NCATE curriculum guidelines and State Department of Education Full, Subject Matter Competencies for early childhood, elementary and special education.

(8) Teacher candidates must have a minimum of 45 hours of diverse field experiences prior to their student teaching experience.

(9) Teacher candidates are provided with advisement services to assist them in taking course work designed to maximize their ~~opportunity~~ opportunities for certification and employment. At a minimum, teacher candidates ~~are made aware~~ provided information on of the latest supply and demand information concerning teacher employment, state salary structure, and ~~are encouraged to seek secondary endorsements if appropriate~~ teaching shortage areas.

(10) Substantive collaboration and classroom interaction with students accompanies theoretical curriculum, thus allowing teacher candidates the opportunity to apply theory to actual classroom situations.

(11) Instruction integrates pedagogical competencies or skills with experiences in the school setting.

(12) Teacher candidates are provided with opportunities to have parental, family and community involvement within their pre-service programs.

(13) The unit establishes and publishes a set of criteria/competencies for exit from each professional education program. These criteria/competencies reflect the Oklahoma Department of Education General Teacher Competencies and/or subject matter competencies outlined in the NCATE national (professional) learned societies' guidelines.

(14) The unit establishes and publishes the criteria/competencies for exit and satisfactory completion of the residency program adhering to all rules and regulations established by the Oklahoma State Department of Education.

(15) A candidate's mastery of a program's stated exit criteria or competencies is assessed through the use of multiple sources of data such as culminating experience, portfolios, interviews, videotaped and observed performance in schools, standardized tests and course grades.

(g) The following guidelines are to be used to facilitate the professional development of faculty:

(1) Teacher education faculty continue their professional development during their tenure at an institution of higher education to ensure that the future teachers of Oklahoma are taught by professional educators fully trained in their areas of expertise. Professional development for teacher educators and arts and sciences faculty should be focused on the faculty members ability to model such effective teaching strategies as inquiry, group discussions and collaborative learning.

(h) The following policies are to be used to evaluate individual program areas at each institution:

(1) The institution shall submit program reviews for each required program area based upon the guidelines and accreditation schedule of the Commission.

(2) Following the completion of each program evaluation, the institution will receive written notification of each program's status. Recognition decisions will include the following categories: recognized, recognized with conditions, recognized with probation, further development required, and not recognized.

(3) If the program is recognized, it will retain its status through the semester and year of the institution's next accreditation visit. To retain recognition, another program report must be submitted before that review.

(4) If the program is recognized with conditions, a report addressing the conditions to recognition must be submitted within 18 months of the date of the status report. The report must address the conditions specified by the reviewers. Once acceptable data has been submitted, the condition(s) will be removed. If the program does not submit acceptable information within the designated timeframe, the decision reverts to "not recognized."

(5) If the program decision is recognized with probation or further development required, a revised report addressing the issues identified by the reviewers must be submitted within 12 ~~to 14~~ months, or the unit may submit a new program report for recognition within 12 ~~to 14~~ months. If the revised report adequately addresses the concerns cited by reviewers, the program decision will be changed to "recognized" or "recognized with conditions." If the program is unsuccessful after two attempts, the program status will be changed to "not recognized."

(6) A program can receive a decision of "not recognized" only after two submissions are unsuccessful in reaching either "recognized" or "recognized with conditions." If the program is not recognized, a revised report addressing unmet standards may be submitted within ~~18~~ 12 months of the date of the recognition report. [This report will be sent to the original team if possible.] The unit may elect to submit a new program report for recognition within ~~18~~ 12 months. [This report will be sent to a new team of reviewers]. The BOE team will automatically cite the non-recognized program(s) as Area~~s~~ for Improvement.

(7) Programs which ~~are required to submit program reviews to NCATE and which~~ receive an initial "recognized with probation" or "further development required" decision ~~from NCATE~~ may apply to OCTP for state recognition and thus recommend teacher candidates for certification under the following conditions:

(A) The program must have an aggregated pass rate of all candidates on the Oklahoma Subject Area Test (OSAT) of 80% or more over a three-year period. An application must be submitted to OCTP containing basic program information as well as current ~~NCATE~~ recognition status and future submission deadlines, but will not require an additional review.

(B) Institutions must submit a revised program report ~~to NCATE~~ according to applicable NCATE/SPA or OCTP guidelines as appropriate addressing concerns cited in the review. If the revised report is not recognized, the unit must submit a second revised report according to ~~NCATE~~ guidelines.

(C) Programs which do not meet the required 80% pass rate on the OSAT may apply to OCTP for state recognition only following three unsuccessful submissions ~~to NCATE~~. The application for state recognition must address concerns cited by reviewers in the final report.

(D) Programs receiving state recognition under these conditions will maintain recognition until the ~~NCATE~~ submission period prior to the unit's next scheduled accreditation visit, at which time the unit will be expected to submit a program review to NCATE or OCTP, as appropriate.

(8) Units may receive conditional approval for new programs. These programs must undergo ~~initial, mid-program, and final~~ reviews as outlined in the New Certification Program Procedures for Established Units guidelines before receiving full recognition. Recognition will be retained through the semester and year of the unit's next accreditation visit.

(9) Programs that do not comply with the procedures detailed in items (h)3-7 will no longer be eligible to recommend candidates for licensure and certification.

(10) An institution with a non-compliant program may apply to the PAC for a waiver if there is evidence that the non-compliant status of a program is due to transitioning national standards.

712:10-5-4. Standards for Oklahoma Teacher Education Programs

(a) The following standards as defined by the National Council for Accreditation of Teacher Education shall apply to undergraduate and graduate programs.

(1) Standard One: Candidate Knowledge, Skills and Dispositions.

(A) Candidates preparing to work in schools as teachers or other professional school personnel know and demonstrate the content, pedagogical, and professional knowledge, skills, and dispositions necessary to help all students learn. Assessments indicate that candidates meet professional, state, and institutional standards.

(B) Elements for Standard One include content, pedagogical and professional knowledge; dispositions for all candidates; and student learning for all candidates.

(2) Standard Two: Assessment System and Unit Evaluation.

(A) The unit has an assessment system that collects and analyzes data on the qualifications of applicants, the performance of candidates and graduates, and unit operations to evaluate and improve the unit and its programs.

(B) Elements of Standard Two include data collection, analysis, and evaluation; and use of data for program improvement.

(3) Standard Three: Field Experiences and Clinical Practice.

(A) The unit and its school partners design, implement, and evaluate field experiences and clinical practice so that teacher candidates and other school personnel develop and demonstrate the knowledge, skills, and dispositions necessary to help all students learn.

(B) Elements of Standard Three include collaboration between the unit and school partner; design, implementation, and evaluation of field experiences and clinical practice; and candidates' demonstrations of the knowledge, skills and dispositions necessary for student learning.

(4) Standard Four: Diversity.

(A) The unit designs, implements, and evaluates curriculum and experiences for candidates to acquire and apply the knowledge, skills and dispositions necessary to help all students learn. These experiences include working with diverse higher education and school faculty, diverse candidates, and diverse students in P-12 schools.

(B) Elements of Standard Four include design, implementation, and evaluation of candidate experiences relevant to diversity.

(5) Standard Five: Faculty Qualifications, Performance, and Development.

(A) Faculty are qualified and model best professional practices in scholarship, service and teaching, including the assessment of their own effectiveness as related to candidate performance; they also collaborate with colleagues in the disciplines and schools. The unit systematically evaluates faculty performance and facilitates professional development.

(B) Elements of Standard Five include hiring of qualified faculty, modeling of best professional practices, ongoing evaluation and professional development and collaboration.

(6) Standard Six: Unit Governance and Resources.

(A) The unit has the leadership, authority, budget, personnel, facilities, and resources including information technology resources, for the preparation of candidates to meet professional, state and institutional standards.

(B) Elements of Standard Six include evidence of leadership within the unit and across the institution, the unit budget, personnel and other resources.

(b) **Teacher candidate portfolios.**

(1) Institutions shall require all initial and advanced certification program(s) students to develop a portfolio following the guidelines outlined in this section.

(2) A portfolio is a documented profile of an individual's accomplishments, learning, and strengths related to the competencies, state and national standards, and outcomes established by the Commission, State Regents, SDE and the institution.

(3) The portfolio, for purposes related to institutional accreditation is a unit of measure which presents evidence that the institution is providing initial, on-going, and focused opportunities and avenues which lead to student achievement of competencies, state and national standards and outcomes determined by the Commission, Regents, SDE and institution.

(4) Institutions will provide for review during each regularly scheduled accreditation visit:

(A) The unit's portfolio handbook containing a written philosophy related to portfolio development and assessment which is consistent with the institution's and unit's mission and conceptual framework, as well as written policies, criteria, and institutional rubric(s) related to the assessment of the portfolio as a whole or individual artifacts contained in the portfolios for all individuals enrolled in initial and advanced programs.

(B) Two representative candidate portfolios for each program offered. OCTP will randomly select one candidate portfolio in each program area and the second will be selected by the_unit. Portfolios should represent candidates at the final transition point.

(C) In addition, annual reports must include any revision in the institution's portfolio process.

(5) Institution's pre-service and/or advanced portfolio process.

(A) The teacher education unit and programs shall:

(i) Require the portfolio development process to begin with enrollment into the professional education course work;

(ii) Have a written portfolio handbook(s) containing a written philosophy related to portfolio development and assessment which is consistent with the institution's and unit's mission and conceptual framework(s);

(iii) Have written policies, criteria, and institutional rubrics related to the portfolio assessment(s) of individual(s) enrolled in initial and advanced certification programs.

(c) **Annual report.** There will be an annual report submitted to the Oklahoma Commission for Teacher Preparation. This report will satisfy the requirements for the Commission for Teacher Preparation, State Regents for Higher Education, State Department of Education, and NCATE/AACTE. The following information will be included in the report:

(1) Changes that occurred in implementation of the standards outlined in the Institution Plan as a result of local and statewide evaluations/assessments, public hearings or other reasons;
(2) Progress made in addressing the areas for improvement, if any, identified by the most recent on-site visit by the on-site accreditation review team;
(3) Quantitative data related to the unit's programs as required in the AACTE/NCATE Annual Report. These data shall reflect information pertaining to supply and demand for teacher candidates;
(4) Program changes being implemented for OCTP and NCATE continued accreditation;
(5) Report on resources devoted to technology;
(6) Report on professional development activities of faculty;
(7) Report on the number of hours each faculty member taught in public schools;
(8) Report on the number of graduate students admitted conditionally and the success rates.
(9) Report on the results of the assessment of teaching skills in the area of reading instruction as administered to candidates in elementary, early childhood education, and special education.
(~~9~~10) Annually, the OCTP shall provide feedback to any institution if their annual report indicates that progress is not being made in addressing program weaknesses.
(~~10~~11) Complete copies of the annual reports for public institutions will be distributed to OSRHE and summary data for all institutions will be distributed to constituents based on reporting requirements outlined in 70 O.S., Section 6-186.
(~~11~~12) OCTP will produce a report describing the accreditation status of each institution. This report will devote a section to each institution separately and include a summary of NCATE and OCTP review findings.

SUBCHAPTER 7. TEACHER PREPARATION TEACHER ASSESSMENT

712:10-7-1. Teacher assessment regulations

(a) **Examinees-initial licensure and certification.**
(1) Any individual who applies for a teaching license/certification must successfully complete the competency examination as defined by the Oklahoma Commission for Teacher Preparation. (70 O.S. 1998 Supp., 6-182(14). The competency examination is made up of three components: The Oklahoma General Education Test (OGET), the Oklahoma Subject Area Test (OSAT) and the Oklahoma Professional Teaching Exam (OPTE).
(2) See Appendix A for competency exam requirements by certification area and test codes.

(b) **Examinees - additional certification.**
(1) Individuals wishing to add a certification area to an existing teaching credential must successfully complete the Oklahoma Subject Area Test for the field of the desired certification.
(2) See Appendix A for competency exam requirements by certification area and test codes

(c) **Examinees - alternative ~~preparation~~ placement program.**
(1) Individuals seeking a teaching license via the Alternative ~~Preparation~~ Placement Program must successfully complete the Oklahoma General Education Test and the Oklahoma Subject Area Test. A licensed teacher via the Alternative ~~Preparation~~ Placement Program seeking a standard certificate must successfully complete the Oklahoma Professional Teaching Exam.
(2) See Appendix A for competency exam requirements by certification area and test codes.

(d) **Examinees-out of state certification.** Individuals seeking an Oklahoma license/certification who are certified educators in another state (s) shall meet the same assessment requirements as all other individuals seeking initial licensure/certification individuals having successfully completed comparable examination(s), as determined by OCTP, shall be exempt from the corresponding part(s) of Oklahoma's assessment requirement.

(e) **Examinees - testing conditions and requirements compliance.**
(1) If an examinee fails to comply with the conditions and requirements specified or referenced in the Certification Examinations for Oklahoma Educators Test Registration Bulletin, including the *Conditions of Test Participation*, or take any prohibited actions, the test results may be voided, no refund will be issued, no portion of the testing fee can be applied toward the cost of any future test administrations and/or the examinee's registration may be cancelled.
(2) If an examinee's test score is found to be unverifiable by either the testing company or the Oklahoma Commission for Teacher Preparation (OCTP), the examinee will be allowed one (1) retake under controlled conditions at no cost to the examinee.

SUBCHAPTER 9. PROFESSIONAL DEVELOPMENT INSTITUTES

712:10-9-1. Professional ~~development~~Development

(a) **Professional ~~development~~Development.~~programs.~~** Professional Development programs should focus on instructional improvement and learning consistent with local control and state goals. ~~Activities~~ It should include, but not be limited to, coaching, mentoring, collaborative work with peers, grade level teams and departmental work, subject area discussions, development of assessments, effective ~~integation~~ integration of instructional technology into the curriculum and analysis of student learning.

(b) **Professional ~~development~~Development ~~institute~~Institute.** Professional ~~development~~Development ~~institute~~Institutes (PDIs) are continuing education experiences that are a minimum of thirty (30) clock hours. The institutes shall be competency-based, emphasize effective learning

practices, require collaboration among participants, and require each participant to prepare a work product which can be utilized in the classroom by the participant.

(1) The Professional Development Institute should:

(A) ~~Be designed to improve~~ Improve instructional effectiveness of teachers and administrators;

(B) Positively impact student learning;

~~(C) Elevate the status of teaching as a profession:~~

(C~~D~~) Improve the school/work environment by encouraging mentoring, collaboration, and teacher involvement in significant decision-making;

(D~~E~~) ~~Be designed with flexibility to provide~~ Provide an effective ~~better~~ professional development that will enhance subject matter knowledge and pedagogical skill of all teachers and administrators;

~~(F) Be designed by a committee composed primarily of teachers, but also include administrators, higher education representatives, citizens and business representatives. All representatives of the committee should be encouraged to attend and participate in professional development institutes whenever possible;~~

(E~~G~~) Include an assessment component that assures maximum accountability for the PDI contractors; ~~and~~

(F~~H~~) Support an environment which allows greater interaction and collaboration among teachers, administrators, and the community-at-large~~.~~; and

(G) Be scientifically research-based;

(2) Professional development institutes administered by the Commission shall:

(A) Be chosen through a competitive bid process in accordance with the procedures established by the Oklahoma Division of Central Services;

(B) Be reviewed by the Commission Professional Development Committee;

(C) Be reviewed by other constituencies as determined by the Commission Professional Development Committee;

(D) Be subject to peer review.

(3) Invitations to Bid related to specific PDIs are ~~is~~ open to any public or private entity for funding consideration and will be subject to peer review as determined by the Commission.

(c) Inner City Schools Rescue Program. The purpose of this program is to recruit and train licensed or certified teachers to work in inner city schools that are on the school improvement list or where 95 percent of the students are eligible for free and reduced lunch.

(1) The Oklahoma Commission for Teacher Preparation will:

(A) Identify schools that meet the criteria;

(B) Provide professional development and support for teachers for the purpose of recruiting and retention in inner city schools;

(C) Inform teachers and administrators across the state of professional development opportunities, grants, and potential partnerships;

(D) Determine a selection criteria and process for participants;

(E) Oversee the applicant review committee.

SUBCHAPTER 11. EDUCATION LEADERSHIP OKLAHOMA

712:10-11-1. Education Leadership Oklahoma regulations

(a) **Selection of scholarship recipients.**

(1) Applicant can be funded for only one ~~scholarship only for National Board for Professional Teaching Standards (NBPTS)~~ Education Leadership Oklahoma (ELO) scholarship to attain National Board Certification.

(2) Applicant must currently be a ~~current~~, full-time, Oklahoma public school classroom teacher ~~from a public school to receive the Education Leadership Oklahoma Scholarship~~. ~~Applicants shall be ranked (from highest to lowest), based on the score of the application,~~ with special consideration given to teachers who work in inner city schools as defined by law~~. In case of a tie score, the locale (under-represented areas of the state) may be given consideration for candidate selection~~.

(3) OCTP shall develop the ELO application and any associated deadlines. The application will seek information in the form of short answer questions and essay.

~~(4) OCTP shall provide candidates, his/her school district and other organizations of the names and contact information of ELO candidates.~~

(~~5~~4) OCTP shall designate the place and time for ELO applications to be read and scored by the Application Review Committee.~~each application review and candidate selection process~~.

(~~6~~5) The Application Review Committee shall review and score applications to award scholarships~~.~~

(A) The ~~selection committee~~ Application Review Committee will ~~consists~~ consist of thirteen ~~members preferably~~ National Board Certified Teachers.

~~(B) The application review committee may serve as oversight of a subcommittee that will read and score Education Leadership Oklahoma applications.~~

(~~C~~B) Each Application ~~review committee~~ Review Committee member~~s~~ ~~will~~ may choose National Board Certified Teachers, as needed, to assist in reading and scoring ELO applications. ~~participate in training to score applications and may train and conduct the application reading with the subcommittee members~~.

~~(D) Each application review committee member may choose up to five classroom teachers, preferably National Board Certified Teachers if available, to assist that member in reading and scoring the applications. The subcommittee members shall be selected by the following guidelines. During their term the subcommittee member shall:~~

~~(i) Have at least three years of teaching experience in an accredited school;~~

~~(ii) Be a full time public school classroom teacher or is and a National Board Certified Teacher;~~

(~~E~~C) ~~The~~ Each Application Review Committee member including National Board Certified Teachers will be trained to read and score applications. ~~members and/or subcommittee members shall serve a term of no more than five years.~~

(D) The Application Review Committee members shall serve a term of no more than five years.

(~~F~~E) If an Application Review Committee member resigns before the end of his/her term, the agency responsible for that nomination will submit a nomination of a person to replace that member.

(~~7~~F) ~~The selection process may include an application with requested information, short answer question(s), and an essay. The items reviewed may include:~~ The Application Review Committee may consider one or more of the following:

(~~A~~i) Knowledge of NBPTS process

(~~B~~ii) Inclusion of the five core propositions within the essay question

(~~C~~iii) Degree to which the applicant's essay conveys his/her application of the five core propositions

(~~D~~iv) Demonstration of community involvement

(~~E~~v) Demonstration of parental involvement

(~~F~~vi) Demonstration of educational achievement

(~~G~~vii) Conveyance of commitment to rigorous process

(~~H~~viii) Provision of quality writing which is clear and sufficiently elaborated

(~~I~~ix) Demonstration of knowledge, ability, and leadership

(~~J~~x) Confirmation of completing the Take One process

(~~K~~xi) Verification of percentage of free/reduced lunch

(~~8~~G) ~~The~~ ELO candidates shall be ~~chosen~~ selected based on scores determined within the application process.

(i) Applicants will be ranked from highest to lowest based on the application scores.

(ii) Special consideration will be given to teachers who work in inner-city schools (as defined by law).

(iii) In case of a tie score, the locale (under-represented areas of the state) may be considered for candidate selection.

(iv) Candidates must attend required Summer Professional Development Institute

(b) **Selection and Utilization of Alternates.**

(1) Alternate must ~~be a current,~~ currently be a full-time, Oklahoma Public School classroom teacher ~~to receive the Education Leadership Oklahoma Scholarship~~.

(2) Alternates shall be ranked from highest to lowest based on the application scores. ~~of the application~~. ~~In case of a tie score, the locale (under-represented areas of the state may be given consideration) for candidate selection.~~

(3) Alternates not selected during the year may reapply for candidacy the following year.

(c) **Payment and reimbursement of assessment fees.**

(1) OCTP shall make assessment fee payments in full ~~to~~ NBPTS for each scholarship candidate, upon signing a contract.

(2) Should a candidate ~~not~~ be ~~able~~ unable to complete the process by the National Board deadline, the following shall apply:

(A) If the candidate withdraws by the National Board deadline and OCTP can recover partial amount of the application fee, the candidate may pay the amount not recovered and will then be ~~placed~~ considered in the next applicant pool.

(B) If the candidate does not withdraw or submit a portfolio by the National Board deadlines, he/she will be responsible to OCTP for the reimbursement of the assessment fee ~~and will not be eligible for another Education Leadership Oklahoma Scholarship.~~

(3) OCTP shall reimburse candidates who pay the National Board assessment fee ~~as long as~~ if they are a full-time public school classroom teacher in the year ~~in which~~ they certify.

(4) OCTP will fund a maximum of two retakes ~~for re-assessment~~ to candidates that bank scores with the NBPTS provided funding is available.

APPENDIX A. COMPETENCY EXAM REQUIREMENTS BY CERTIFICATION AREAS [REVOKED]

APPENDIX A. COMPETENCY EXAM REQUIREMENTS BY CERTIFICATION AREAS [NEW]

	Test Codes		
Subject Area and Grade Level	**OGET**	**OSAT**	**OPTE**
Advanced Mathematics			
6-12	74	11	72 or 76
Agricultural Education			
6-12	74	42	72 or 76
Art			
PK-3	74	2	70
1-8	74	2	71
6-12	74	2	72
PK-12	74	2	73 or 75 or 76
Biological Sciences			
6-12	74	10	72 or 76
Blind/Visual Impairment			
PK-3	74	28	70
1-8	74	28	71
6-12	74	28	72
PK-12	74	28	73 or 75 or 76
Business Education			
6-12	74	40	72 or 76
Chemistry			
6-12	74	4	72 or 76
Cherokee			
PK-12	74	79	73 or 75 or 76
Chinese			
PK-12	74	80	73 or 75 or 76
Computer Science			
PK-12	74	81	73 or 75 or 76
Dance			
PK-12	74	78	73 or 75 or 76
Deaf/Hard of Hearing			
PK-3	74	28	70
1-8	74	28	71
6-12	74	28	72
PK-12	74	28	73 or 75 or 76
Driver/Safety Education			
6-12	74	36	72 or 76

Early Childhood Education			
PK-3	74	05	70 or 75
Earth Science			
6-12	74	08	72 or 76
Elementary Education			
1-8	74	06 or 50 & 51	71 or 75
English			
6-12	74	07	72 or 76
English as a Second Language			
PK-12	74	77	73 or 75 or 76
Family/Consumer Science			
6-12	74	09	72 or 76
French			
PK-3	74	20	70
1-8	74	20	71
6-12	74	20	72
PK-12	74	20	73 or 75 or 76
German			
PK-3	74	21	70
1-8	74	21	71
6-12	74	21	72
PK-12	74	21	73 or 75 or 76
Instrumental Music			
PK-3	74	01	70
1-8	74	01	71
6-12	74	01	72
PK-12	74	01	73 or 75 or 76
Intermediate Mathematics			
6-12	74	25	72 or 76
Journalism			
6-12	74	37	72 or 76
Latin			
PK-3	74	23	70
1-8	74	23	71
6-12	74	23	72
PK-12	74	23	73 or 75 or 76
Marketing Education			
6-12	74	41	72 or 76
Middle Level English			
5-8	74	24	71 or 72 or 75 or 76

Middle Level Math			
5-8	74	25	71 or 72 or 75 or 76
Middle Level Science			
5-8	74	26	71 or 72 or 75 or 76
Middle Level Social Studies			
5-8	74	27	71 or 72 or 75 or 76
Mild-Moderate Disabilities			
PK-3	74	29	70
1-8	74	29	71
6-12	74	29	72
PK-12	74	29	73 or 75 or 76
Physical Education/Health/Safety			
PK-3	74	12	70
1-8	74	12	71
6-12	74	12	72
PK-12	74	12	73 or 75 or 76
Physical Science			
6-12	74	13	72 or 76
Physics			
6-12	74	14	72 or 76
Psychology/Sociology			
6-12	74	32	72 or 76
Russian			
PK-3	74	22	70
1-8	74	22	71
6-12	74	22	72
PK-12	74	22	73 or 75 or 76
Severe-Profound/Multiple Disabilities			
PK-3	74	31	70
1-8	74	31	71
6-12	74	31	72
PK-12	74	31	73 or 75 or 76
Spanish			
PK-3	74	19	70
1-8	74	19	71
6-12	74	19	72
PK-12	74	19	73 or 75 or 76
Speech/Drama/Debate			
6-12	74	16	72 or 76
Technology Education			
6-12	74	43	72 or 76

US History/US Govt/OK Hist/Econ			
6-12	74	17	72 or 76
Vocal Music			
PK-3	74	03	70
1-8	74	03	71
6-12	74	03	72
PK-12	74	03	73 or 75 or 76
Vocational Business Education			
6-12	74	40	72 or 76
Vocational Family and Consumer Sciences			
6-12	74	09	72 or 76
World History/Geography			
6-12	74	17	72 or 76
Advanced Certification Areas (without a current teacher certificate)	**OGET**	**OSAT**	**OPTE**
Library-Media Specialist	74	38	73 or 75 or 76
Psychometrist	74	34	73 or 75 or 76
Reading Specialist	74	15	73 or 75 or 76
School Counselor***	74	39	73 or 75 or 76
School Psychologist**	74	33	73 or 75 or 76
Speech-Language Pathologist*		35	
Advanced Certification Areas (with a current teacher certificate)			
Library-Media Specialist		38	
Psychometrist		34	
Reading Specialist		15	
School Counselor***		39	
School Psychologist**		33	
Speech-Language Pathologist*		35	
Administrator Certification Areas			
Elementary Principal		44 and 45	
Middle Level Principal		44 and 46	
Secondary Principal		44 and 47	
Superintendent		48	

*Candidates seeking a Certificate of Clinical Competence (CCC) who have successfully completed the Praxis exam for Speech Pathology are exempt from Oklahoma assessment requirements.

**Candidates seeking National School Psychologists Certification (NSPC) who have successfully completed the Praxis exam for School Psychologist are exempt from Oklahoma assessment requirements.

***Candidates with the Nationally Certified School Counselor (NCSC) credential are exempt from Oklahoma assessment requirements.

TEST CODES

Test (OSAT)	*Test Code*
Advanced Mathematics	11
Agricultural Education	42
Art	02
Biological Sciences	10
Blind/Visual Impairment	28
Business Education	40
Chemistry	04
Cherokee	79
Chinese	80
Computer Science	81
Dance	78
Deaf/Hard of Hearing	30
Driver/Safety Education	36
Early Childhood Education	05
Earth Science	08
Elementary Education Subtest – Red/Lang Arts/Soc Studies (50) Subtest – Math/Science/Health/Fine Arts (51)	06 or 50 & 51
English	07
English as a Second Language	77
Family and Consumer Sciences	09
French	20
German	21
Instrumental/General Music	01
Journalism	37
Latin	23
Marketing Education	41

Middle Level English	24
Middle Level/Intermediate Mathematics	25
Middle Level Science	26
Middle Level Social Studies	27
Mild-Moderate Disabilities	29
Physical Education/Health/Safety	12
Physical Science	13
Physics	14
Psychology/Sociology	32
Russian	22
Severe-Profound/Multiple Disabilities	31
Spanish	19
Speech/Drama/Debate	16
Superintendent	48
Technology Education	43
US History/OK History/Government/Economics	17
Vocal/General Music	03
Vocational Business Education	40
Vocational Family and Consumer Sciences	09
World History/Geography	18
Test (OSAT – Advanced Programs)	***Test Code***
Library-Media Specialist	38
Psychometrist	34
Reading Specialist	*15*
School Counselor	*39*
School Psychologist	33
Speech-Language Pathologist	*35*
Test (OSAT-Administrator)	***Test Code***
Principal Common Core	44
Elementary Principal Specialty Test	*45*
Middle Level Principal Specialty Test	*46*
Secondary Principal Specialty Test	47
Superintendent	48

Test (OGET)	***Test Code***
Oklahoma General Education Test	74
Test (OPTE)	**Test Code**
OPTE: Early Childhood (PK-3)	70
OPTE: Elementary/Middle Level (1-8 or 5-8)	71
OPTE: Middle Level/Secondary (6-12 or 5-8)	72
OPTE: PK-12	73
OPTE: PK-8	75
OPTE: 6-12	76

[OAR Docket #10-687; filed 4-26-10]

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

1:2010-19.

EXECUTIVE ORDER 2010-19

I, Brad Henry, Governor of the State of Oklahoma, pursuant to the authority vested in me by Sections 1 and 2 of Article VI of the Oklahoma Constitution, in recognition of Peace Officers Memorial Day, direct that appropriate steps be taken to fly all American flags and Oklahoma flags on State property at half-staff from 8:00 a.m. until 5:00 p.m. on Saturday, May 15, 2010, to honor Federal, State and local officers killed or disabled in the line of duty.

This executive order shall be forwarded to the Director of Central Services 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 this 6th day of May, 2010.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:
M. Susan Savage
Secretary of State

[OAR Docket #10-834; filed 5-11-10]

1:2010-20.

EXECUTIVE ORDER 2010-20

I, Brad Henry, Governor of the State of Oklahoma, pursuant to the power vested in me by Section 2 of Article VI of the Oklahoma Constitution, hereby declare the following:

1. Tornadoes, severe storms, and straight line winds beginning on May 10, 2010, and continuing have caused extensive damage to public and private properties within the State of Oklahoma; and said damages have caused an undue hardship on the citizens of this state.

2. It may be necessary to provide for the rendering of mutual aid assistance among the State and political subdivisions of the State with respect to carrying out disaster emergency functions during the continuance of the State emergency pursuant to the provisions of the Oklahoma Emergency Management Act of 2003.

3. There is hereby declared a disaster emergency caused by the tornadoes, severe storms, and straight line winds in the State of Oklahoma that threatens the lives and property of the people of this State and the public's peace, health and safety. The counties included in this declaration are:

Alfalfa, Atoka, Beaver, Blaine, Bryan, Caddo, Canadian, Carter, Cleveland, Coal, Comanche, Cotton, Craig, Creek, Delaware, Dewey, Ellis, Garfield, Garvin, Grady, Grant, Harper, Haskell, Hughes, Jefferson, Johnston, Kay, Kingfisher, Kiowa, Lincoln, Logan, Love, Marshall, Mayes, McIntosh, McClain, Murray, Muskogee, Noble, Okfuskee, Oklahoma, Okmulgee, Osage, Ottawa, Pawnee, Payne, Pontotoc, Pottawatomie, Rogers, Seminole, Sequoyah, Stephens, Tillman, Tulsa, Washita, and Woodward

This declaration may be amended to add counties as conditions warrant.

4. The State Emergency Operations Plan was activated on May 10, 2010, and resources of all State departments and agencies available to meet this emergency are hereby committed to the reasonable extent necessary to protect lives and to prevent, minimize, and repair injury and damage. These efforts shall be coordinated by the Director of the Department of Emergency Management with comparable functions of the federal government and political subdivisions of the State.

5. State agencies, in responding to this disaster emergency, may make necessary emergency acquisitions to fulfill the purposes of this proclamation without regard to limitations or bidding requirements on such acquisitions.

6. This Executive Order shall terminate at the end of thirty (30) days.

Copies of this Executive Order shall be distributed to the Director of Emergency Management who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, this 11th day of May, 2010.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Brad Henry

ATTEST:
Michelle Waddell
Acting Assistant Secretary of State

[OAR Docket #10-835; filed 5-11-10]

1:2010-21.

EXECUTIVE ORDER 2010-21

I, Brad Henry, Governor of the State of Oklahoma, pursuant to the power vested in me by Sections 2 of Article VI of the Oklahoma Constitution, 63 O.S. §§ 683.1 et seq., and pursuant to Title 49 CFR Part 390.23 hereby declare that because there is a state of emergency continuing in the State of Oklahoma due to catastrophic weather occurring statewide, it is necessary to assist and expedite all efforts of storm relief. In order to accommodate this need and to provide assistance to the citizens of Oklahoma in this extraordinary situation, I hereby order the temporary suspension of the following as they apply to vehicles used in the support efforts:

1. The requirements for special permits for use of oversized vehicles under Title 47;
2. The requirements for special permits for use of overweight vehicles operating off the interstate highway system under Title 47;
3. The requirements for licensing/operating authority as required by the Oklahoma Corporation Commission;
4. The requirements for licensing/registration as required by the Oklahoma Tax Commission and the Oklahoma Corporation Commission;
5. Exemption from Parts 390 through 399 of Title 49 of the Federal Motor Carrier Safety Regulations.

This Executive Order provides relief for 30 days from Sections 390 through 399 of the Federal Motor Carrier Safety regulations for those interstate and intrastate carriers who are providing direct assistance for the immediate restoration of essential services (such as electrical, sewer, water, and telecommunications) or essential supplies (such as food and fuel). It does not include transportation related to long-term rehabilitation of damaged physical infrastructure or routine commercial deliveries after the initial threat to life and property has passed. Direct assistance terminates when a driver or commercial motor vehicle is used in interstate or intrastate commerce to transport cargo not destined for the emergency relief effort, or when a motor carrier dispatches such driver or vehicle to a location outside the relief area.

Nothing contained in this Executive Order shall be construed as an exemption from the Controlled Substance and Alcohol Use and Testing requirements (49 CFR Part 382), the Commercial Driver License requirements (49 CFR Part 383), the Financial Responsibility requirements (49 CFR Part 387), or any other portion of the regulations not specifically identified herein. Motor carriers that have an Out-Of-Service Order in effect cannot take advantage of the relief from regulation that this declaration provides.

Consistent with Title 49 CFR Part 390.23 this Executive Order will remain in effect for 30 days, beginning May 11, 2010, and ending June 10, 2010.

Copies of this Executive Order shall be distributed to the Director of Emergency 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, this 11th day of May, 2010.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Brad Henry

ATTEST:
Michelle Waddell
Acting Assistant Secretary of State

[OAR Docket #10-836; filed 5-11-10]